

Annual Report and Accounts 2019-20



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Chair and Chief Executive's Foreword

It gives us great pleasure to present this Annual Report that outlines many of the Trust's successes and achievements, challenges and opportunities over the past twelve months.

The year has been pivotal for our Trust and for mental health services in general and forged a solid foundation, through our work in preparation for the merger with Black Country Partnership NHS Foundation Trust, to create the highest quality mental health service provision across the Black Country.

Our merger has been a major focus throughout the year in order for us to harness the opportunities that bringing together mental health and learning disability services across the Black Country offers.

We would like to take this opportunity to thank staff and stakeholders for their support and commitment over the past 11 years.

The year progressed with many highlights and proud moments for our Trust but, as with the rest of the health sector, it ended with the beginning of a global pandemic. Quite rightly our focus, our ways of working and our priorities towards the end of the year has been to support our service users and our staff through the challenges of Covid-19.

Ahead of the pandemic, we achieved some notable milestones. We were delighted to maintain our CQC rating of "good" following a well-led inspection. The past three years has seen us make steady progress towards "outstanding" and puts us in a strong position to make even further progress in 2020 / 21 as a merged Trust.

Our excellent staff survey results again, show that staff engagement remains high and we are one of the top performing trusts in many areas. The link between an engaged workforce and the delivery of high quality services is well proven and therefore this will continue to be a key element of our future strategies.

The NHS ten year plan brought with it a significant shift in focus for our services along with considerable investment with which we are able to ensure that more people receive the care they need at the right time and in the right place.

During the year we benefited from this investment bringing some new and enhanced services to the Black Country for example the strengthening of our crisis services in the community and in acute settings including a new helpline providing 24 / 7 access and a crisis cafe; improving mental health services in-reach into Schools and expansion our dedicated employment support services for our service users.

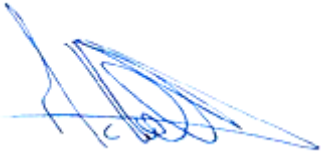
None of this could be achieved without the dedication and enthusiastic support from everyone who worked for the Trust. The Board recognises this and has placed considerable emphasis on listening to our colleagues and responding to the issues they have raised.

And finally, we are very proud of how our staff faced into the challenges of the covid-19 pandemic towards the end of the year, adapting quickly to new ways of working and facilitating change at pace, whilst keeping each other and our service users safe. To support our staff, we built on our staff health and wellbeing services to provide wide ranging support accessible to all staff.

The covid-19 pandemic will inevitably reshape our focus for the year ahead as a merged Trust and will bring much learning, opportunity and change. Our focus for the year ahead is aimed at learning from our experiences of the pandemic to reap the benefits of our learning across our services and within our communities.

As a merged Trust we have a great opportunity to reimagine mental health and learning disability services for the Black Country.

The Board would like to thank everyone who has worked for and with the Trust over the past year for their continued and unprecedented commitment to delivering high quality services.

A handwritten signature in blue ink, appearing to read 'Mark Axcell', with a stylized, overlapping structure.

Mark Axcell
Chief Executive Officer

A handwritten signature in blue ink, appearing to read 'Jeremy Vanes', with a cursive style.

Jeremy Vanes
Chair

PART A PERFORMANCE REPORT

1 OVERVIEW

1.1 About the Trust

The Trust is a multi-site provider (26 sites) of mental health and social care services serving the Black Country boroughs of Dudley and Walsall within the West Midlands. We also have some services across the Black Country and in neighbouring counties.

The Trust headquarters is situated in Dudley, approximately 10 miles north-west of Birmingham. We employ around 1300 staff and the Black Country region demonstrates cultural, economic and educational diversity. Walsall, along with Sandwell and Wolverhampton, experience higher than average levels of multiple deprivation.

The Trust is regarded as a high performing, well managed organisation and has built a reputation across the health economy as a collaborative and responsive partner and an exemplar employer.

We are a relatively small yet flexible organisation, responding to change and challenge, quickly and effectively.

We are especially proud of:

- Open and transparent culture
- Excellent staff engagement evidenced in our staff surveys
- Reputation for good service quality and robust governance processes
- Consistently high performance
- Robust relationships with commissioners and other partners across our STP
- Inclusive engagement with service users, carers, agencies and community groups

Figure 1 Key Statistics 2019 / 20 outturn

Statistic	2019 / 20
Population Served	Dudley 320,600; Walsall 283,400
Total Employees	1362 Healthcare Staff, 50 social care staff
Number of Sites	26
Total Inpatient Beds	163
Number of Main Commissioners	2
Total Income	81,986
CCG Income from patient care activities	75,398
Other Patient Care Income	955
Income from non-healthcare sources	5,633
Service User activities	c357,700
Total Outpatient Attendances	16,252
Total Inpatients Treated	1.205

1.1.1 *Highlights and Successes of 2019 /20*

In 2019 / 20, we continued to focus on maintaining the delivery of high quality services, evidenced by our performance against national and local indicators as well as feedback from our service users and carers. Below are some of the highlights from 2019 / 20.

- Continued to be rated GOOD by the CQC and outstanding for 'caring' in our Children and Adolescent Mental Health Services
- Our staff survey results were excellent - staff engagement remains high and we are one of the top performing trusts in many areas
- Successful merger to create Black Country Healthcare NHS Foundation Trust
- We continued our involvement in developing plans for mental health service delivery as part of the Black Country and West Birmingham Sustainability and Transformation Plan (STP)
- Implemented Institute of Leadership & Management (ILM) for leadership and coaching which links to the CQC domain of a well led organisation
- Developed a group of facilitators to deliver the Forward Thinking Leadership programmes which will have a direct impact on equality, diversity and inclusion
- Established three Networks which include, Disability, BME and LGBTQ. Staff Equality Networks are recognised as an important and effective mechanism for ensuring that staff members from protected groups, and other groups at potential risk of inequality, are enabled to develop a meaningful voice into the organisation, so that their experiences, concerns and aspirations can be heard.
- Improved recruitment and retention of Registered Nurses through a range of methods including launch of a return to practice campaign in partnership with Black Country Partnership NHS Trust and the University of Wolverhampton
- Recruited 5 Cultural Ambassadors and have developed a standard operating procedure, which will ensure fairness in how BME staff are treated.
- Significant progress made in rolling out a new patient administration system RiO
- We have expanded the range of apprenticeships introducing access to degree level Leadership and Management apprenticeships
- Strengthened our Research and Innovation (R & I) function to recruit more patients to studies; appoint a Head of R & I; support quality improvement programmes
- Launched a new Trust Suicide Prevention Strategy encompassing a communication campaign and staff pledge to support a Zero Suicide Ambition
- Exceeded our target, achieving our highest ever uptake rate for flu vaccinations protecting our staff and service users from the flu virus
- Became a 'Smoke Free' Trust in September 2019 creating a healthier environment for our patients, visitors and staff

Quality and operational highlights are described in later sections of this part of the report.

1.2 Vision, Values and Strategy

1.2.1 Our Vision

The Trust's vision is one of a recovery-oriented service. The vision, encapsulating the concept of the benefits arising from a single mental health trust for the communities we serve is shown below:

Better Together - delivering flexible, high-quality, evidence-based services to enable people to achieve recovery.

The Trust's vision has been guided by national, regional and local intelligence and strategies where there is a growing emphasis on the well-being of the population and a focus on prevention, together with early detection and intervention.

1.2.2 Our Values

Our values are the essence of our identity. They describe what we are and what we stand for. They support our vision, shape the culture and more importantly represent the behaviours that staff value as employees.

A few years ago, we refreshed our values in close partnership with staff. This was a process that engaged all staff in revisiting what they felt were important values for us and that would shape our guiding principles and underpin the way we work.

We embedded these values through our behavioural framework that is used in recruitment, appraisals and supervision.

Today our values are lived and breathed and as a result we have excellent feedback from our staff surveys about our culture, our warm and friendly welcome to new staff, our approach to supporting staff and creating a place where staff are free to speak up and have their say.

Figure 2 Our Values



1.2.3 Our Strategy

The Trust has a clear, focused strategy that underpins the delivery of mental health services for the populations of Dudley and Walsall. In protecting its long term viability, the Trust explores opportunities that support the delivery of mental health services across the wider health economy, building on the skills of the Trust and meeting unmet or emerging needs.

In developing its strategy, the Board stated its commitment to be flexible in its on-going consideration of the scope of services it provides in order to reflect the genuine needs of service users and carers and delivery of the Five Year Forward View (5YFV) and the new NHS ten year plan.

1.3 Our partnerships

1.3.1 *Merger with BCPFT*

Work progressed on the coming together of the Trust and BCPFT culminating at the very end of the year with our merger being approved by the Secretary of State and our regulators.

During the year we engaged with staff to start to create a new vision, brand, identity and a new set of values that represent our combined aspirations and ambition. Staff voted on a new name for the merged Trust and the most popular (at over 80%) was:

Black Country Healthcare NHS Foundation Trust

Towards the end of the year we also started to shape our new priorities for the year ahead with the main focus on delivering:

- the priorities set out in the long term plan
- successful integration of our services
- establishing and supporting the Dudley Integrated Health and Care NHS (DIHC)

The emergence of the global covid-19 pandemic in March 2020 did however cause us to pause on some of these plans and reflect on our priorities. Our revised priorities are described later in Section 1.8 Our 2020 / 21 Plans.

1.3.2 *Black Country and West Birmingham STP*

By 2021 all STPs will have transitioned into Integrated Care Systems, bringing together our local organisations to redesign care and improve population health.

The Trust is involved with the STP at all levels and in particular, is working in partnership with BCPFT and commissioners to explore which mental health services can be delivered at scale across the Black Country.

We reviewed 11 services as well as a number of other opportunities including perinatal mental health, female PICU, expansion of IPS services, liaison and diversion and bed management including Out Of Area placements.

Our role as a system partner has developed over the year and we are working closely to ensure that mental health services are receiving the investment needed to meet the needs of our communities. Our commissioners across the STP are working closely to streamline commissioning and commissioning decisions to support this.

1.3.3 *Supporting place based models of care*

Local place-based models of care (ICAs) are being developed and implemented for each of the four STP boroughs. These ICAs are a means to bring together health and care services for defined populations.

For both boroughs we have been working together to agree which services are best delivered at a place based level, borough level or at scale across the Black Country. The current plan is for primary care mental health services including IAPT to be delivered at a place based level close to or in primary care / GP settings.

Core community and inpatient services will continue to be delivered in each borough coordinated in conjunction with place based partners and the "STP 11", inpatients and further service developments will form the basis of a pan Black Country delivery model.

Dudley IHC – the Trust has been a key player in the development of Dudley IHC Clinical model since its inception. We have been instrumental in developing the model for place based care and successful MDT working. Moving forward we continue to shape the clinical model for Dudley and support ongoing engagement with stakeholders around the development of the organisational model.

In April, when the DIHC will be formed, our IAPT and Primary Care Mental Health services will be transferred into the DIHC and will be supported by Black Country Healthcare NHS Foundation Trust corporate services.

Walsall Together – Walsall Together is gathering pace and we are involved at all levels of the development of integrated care plans. Clinical engagement events are being planned so that we can shape the clinical model together, learning from our work with Dudley IHP and the STP.

The Trust has been successful in embedding a robust reputation across the local health economy and beyond through proactive engagement in a number of strategic partnerships.

These partnerships play a fundamental role in our future organisational development and form the basis on which we will support new models of care and long terms sustainability of local services.

In particular, we have worked with commissioners in our two boroughs to develop place based models of care that focus on taking services traditionally provided in hospitals into the community, bringing care nearer to patients' homes. The principle behind the place based care is multi-disciplinary working with appropriate services being more closely aligned to the communities where people live.

1.3.4 *MERIT*

Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) Vanguard – an Acute Care Collaboration to develop new ways of working in mental health and reducing variation in care, involving the Trust, Black Country Partnership NHS Foundation Trust, Coventry and Warwickshire Partnership Trust and Birmingham and Solihull Mental Health NHS Foundation Trust.

The scope and remit of MERIT has changed over the year and the membership has been extended to other providers across the West Midlands with the aim of working collaboratively on New Care Models for CAMHS, Eating Disorders and LD / autism.

As part of our response to Covid-19 we have started to work closely with MERIT partners on a number of work streams such as forecasting demand and capacity, new ways of working and recovery planning.

1.3.5 *Other partnerships*

West Midlands Combined Authority – Within our STP, we work collaboratively to deliver the WMCA THRIVE project, the largest randomized control trial in Europe, providing employment support services to mental health service users.

Local Authorities – the trust works partnership with our local authorities to provide integrated social care services.

Third Sector – we work closely with a wide range of third sector providers to provide services in partnership and to provide appropriate sign posting for our service users and carers. An example of this is the co-location of Rethink staff within our crisis service.

1.3.6 *Review of progress against our 2019/20 corporate priorities*

In the table below, we present a review of progress against the 2019 / 20 priority activities. We reviewed the current position with regard to priority activities that are either complete or carried forward into next year or into business as usual.

The table below shows our priorities framework.

Figure 3 2019 / 20 objectives framework

Strategic Domain	Trust Priority 2019 / 20	Exec Lead	Committee
High quality services	1. Continue to develop and improve services in line with our quality improvement strategy, the ten year plan, parity of esteem and local integrated care systems	Marsha Foster	Q and S and MEXT
Inclusive partnerships	2: Develop a framework to support co-production with staff, service users and other stakeholders	Rosie Musson	Q and S
Leadership Culture	3: Nurture our workforce through a greater focus on staff health and wellbeing	Ashi Williams	Workforce
Responsible workforce	4: Workforce optimisation – building a multi-disciplinary clinical workforce that will support service delivery at all levels	Mark Weaver	Workforce
Supporting strategies	5: Manage a successful merger to ensure that we remain resilient, that best practise prevails and that we build on the strengths of the partnerships	Mark Axcell	MEXT
Effective & efficient resources	6: Make better use of technology and IT infrastructure to improve quality, productivity and effectiveness	Robert Pickup	F & P

Under the six corporate objectives, there are 72 key milestones and it is these that are managed and monitored. At the end of Q3, 59 of the 72 milestones were complete or on track.

A Q4 review is underway and will of course be impacted by Covid-19 and the necessary refocus towards the end of the year. However, as we work to define our priorities for 2020/ 21 we will need to take into consideration our year-end position.

1.4 Our Services

Mental health conditions are very common with 1 in 4 people experiencing some kind of mental health problem in the course of a year. These are split into two categories; “common mental health problems”, which include conditions such as depression and anxiety, and “severe and enduring mental health problems” such as schizophrenia and bipolar disorder.

The Trust provides a full range of mental health treatment and rehabilitation services that manage both categories of mental health conditions. The Trust’s range of services spans GP based primary care based counselling and psychological therapies for common mental health problems through to the treatment and care of people detained under the Mental Health Act.

Core services are provided predominately to Dudley and Walsall, but also to neighbouring Trusts in Worcestershire, Staffordshire, Birmingham and Warwickshire. We provide:

- Community mental health services for children, adults & older people
- Inpatient services for adults and older people, including Home Treatment
- Crisis and Urgent Care including Street Triage
- Primary Care Mental Health services
- Improving Access to Psychological Therapies (IAPT) – in primary care
- Mental Health Social Care Services (via local authority partnership)
- Psychological Therapies in secondary care

- Employment, education and training support for people with mental health problems and long-term conditions
- Psychiatric Liaison Service at both acute hospitals
- Specialist Deaf CAMHS (national hub)
- Criminal Justice Mental Health Services
- Liaison and Diversion Services (in partnership with BCPFT)
- Adult Neurodevelopmental Service – regional service
- Early Intervention in Psychosis Service

1.4.1 Operational services

Our services are organised as shown below. Black Country wide services are marked with *. Regional services are marked with **. We have made some changes this year to our service lines which are reflected below. Social care services have remained integrated in Adult and Older Adult services in Dudley this year but the Council has stated its intention to move its services back over the course of the next year.

Figure 4 Our Operational Services

Service Area	Services
Urgent Care, Access & CAMHS Services	<ul style="list-style-type: none"> • Primary Care Mental Health • Improving Access to Psychological Therapies (IAPT) • Early Access Service • Mental Health Assessment Service • Crisis Service • Street Triage * • Psychiatric Liaison • Place of Safety • CAMHS • I-CAMHS • Deaf CAMHS**
Inpatient & Home Treatment Services	<ul style="list-style-type: none"> • Adult inpatient wards • Older adult inpatient wards • Home Treatment • Inpatient Therapeutic Hub • Electro-Compulsive Therapy • Transcranial Magnetic Stimulation **
Specialist Services	<ul style="list-style-type: none"> • Early Intervention in Psychosis • Adult Neurodevelopmental Service (ASD and ADHD)** • Complex Care Service • Liaison and Diversion – Black Country * • Liaison and Diversion – Worcester • Criminal Justice Team * • Eating Disorder Service • Perinatal Services *
Community Services	<ul style="list-style-type: none"> • Community Recovery Service • Enhanced Older Adult Community Mental Health Teams • Psychological Therapies Hub • Employment Services/Thrive/IPS * • Memory Assessment Service • Outpatients

1.4.2 Medical services

The medical directorate consists of all medics, medical secretaries, medical records, postgraduate department and pharmacy services.

The medical workforce has significant involvement in service delivery planning including partnership involvement in the DIHC and Walsall Together partnerships. We have established a clinical senate that provides a multi-disciplinary forum.

Medical Temporary staffing usage is well managed and in line with the agency cap rates.

The Pharmacy service includes clinical and technical pharmacy services to inpatient / home treatment, Medicines reconciliation, Patient counselling, Medicines information, Formulary management and Antimicrobial stewardship.

The Trust is progressing with a single pharmacy provider service, covering Black Country mental health services. The single provider service will supply pharmaceuticals to mental health services across the region and will incorporate an electronic prescribing and administration system.

The pharmacy team continue to support work experience placements and undergraduate placements as part of a programme that supports research/service evaluation.

1.4.3 Corporate / support services

Behind our front line services are small yet effective back office / clinical support services that provide mainly in-house services to support service delivery and effective running of the Trust. They are shown below.

Figure 5 Corporate / Support Services

Corporate services	Corporate operational services
Workforce and recruitment	Quality improvement
Payroll (via contract with The Royal Wolverhampton NHS Trust)	Patient safety
Learning and development including library services	Clinical governance and audit
Financial services	Infection prevention and control
Estates	Research and development
IM&T (provided partly by Dudley Group NHS Foundation Trust)	Facilities management (ISS contract)
Communication and engagement	Health and safety
Service Experience desk (including PALs)	Safeguarding
Information governance	Nurse development
Programme management office	
Corporate governance	
Internal Audit (CW) and External audit (Grant Thornton)	
Information and Performance	

The Trust will maximise the opportunities created by our merger to develop Corporate Services that can meet the demands of our growing clinical services.

Integration of these services will also reflect the learning from new ways of working during covid-19 such as greater agile and home working, online / digital service delivery and services changes.

1.4.4 *Service improvements and developments*

In the past year we have received support to develop new, or enhance existing services, some examples are shown below:

- Continuation with the ward refurb programme with 2019/20 seeing improvements made to Clent Ward and Langdale Ward At Bushey Fields Hospital
- Further developments in inpatient staffing establishment with introduction of new roles such as the Band 4 Nurse associates and RGN/RNLD posts
- Successful improvements made with retention and recruitment for example inpatient vacancy levels dropped from around 15% to just over 5% and turnover fell from 10% to 8%
- Improvements made with bed occupancy and reducing ALOS leading to small % of out of area admissions
- Additional funding to develop Crisis Resolution/Home Treatment Services to meet the core fidelity model
- Introduction of joint venture for piloting crisis alternatives
- Successful AIMS accreditation maintained across inpatient wards
- Successful ECTAS accreditation maintained
- Development of TMS towards delivering private care
- Expansion of Employment Retention Service in Dudley approved and piloted.
- Memory Assessment Service retained MSNAP Accreditation from Royal College of Psychiatrists
- Appointment of Out Patient Clinic Manager leading Optimisation of Out Patients alongside Clinical Director
- Development of transition service for Children and Young People
- Developments with acute partners to enhance patient experience and assessment process in Eating Disorder Services
- Continued expansion of the Adult Neurodevelopmental Service (ANS) to help meeting growing demands of the service
- Mental Health Support to the Homeless project in Walsall successfully piloted

1.4.5 *Raising the quality of our services*

The Trust has a robust approach to quality improvement. The quality of our services, safety, effectiveness and experience are at the heart of everything that we do.

In 2019/20 we have continued to implement our second Quality Improvement Strategy 2016 – 2020, delivering an annual cycle of quality improvement, evidenced through our Quality Account.

Key features of the Quality Improvement Strategy are:

- Its alignment with the national drivers and the Trusts clinical and social care vision and values
- Its support for the delivery of a year on year Quality Improvement programme which has included a number of ambitious Trust wide goals that have reflected local and national priorities. This has been evidence in our Quality Account

Its' aim to:

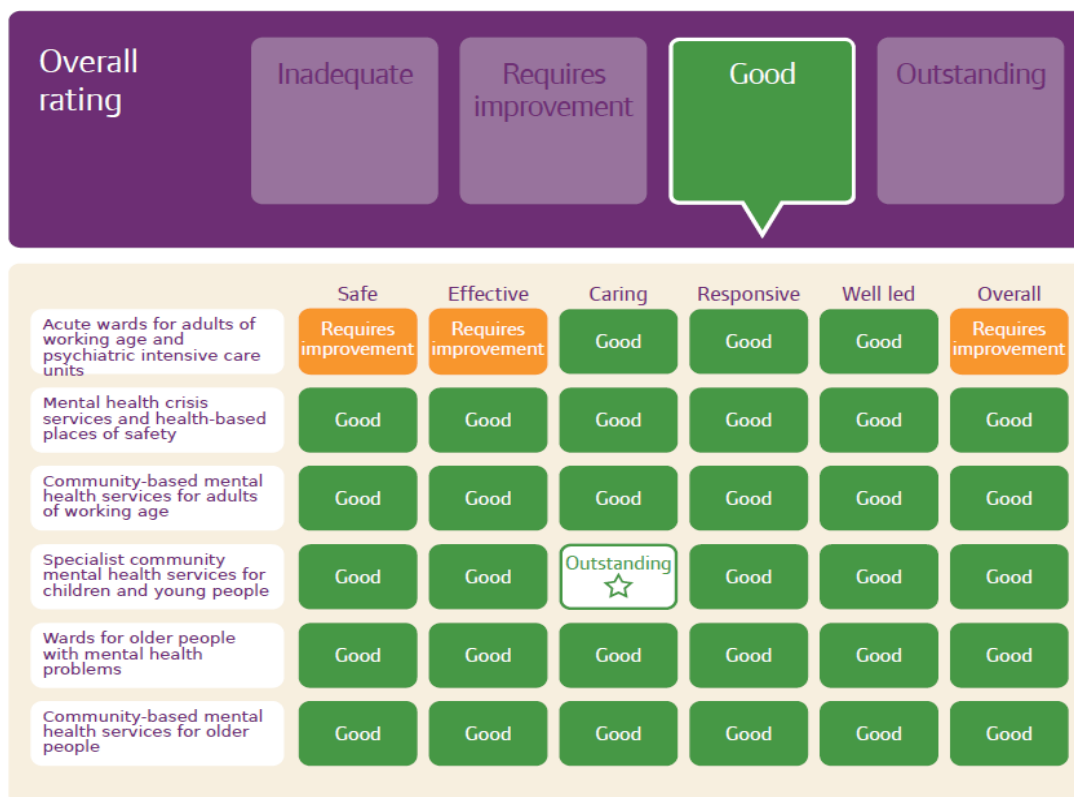
- Support the development of a culture of continuous quality improvement which results in higher satisfaction and experience for service users, carers and their families
- Engage every member of staff because as quality is everyone's business and they have a key role to contribute to quality experience and continuous improvement
- Set out how goals for improvement will be identified and set
- Set out how we will measure and publish progress

The strategy is implemented through the Trust's Quality Governance Framework. Service user and carer, staff and stakeholder engagement remains fundamental to the delivery of the strategy. Progress and impact is monitored through the Quality and Safety (Q&S) Committee and Trust Board.

1.4.6 Quality highlights

In 2019 / 20 we were delighted to remain rated GOOD by the CQC and outstanding for 'caring' in our Children and Adolescent Mental Health Services (CAMHS). Below is our high level CQC rating.

Figure 6 CQC rating



Below are some of our other quality highlights from 2019/20:

- Maintained Royal College of Psychiatrists Accreditation for Inpatient Mental Health Scheme (AIMS), Memory Services National Accreditation Programme (MSNAP) accreditation and Electroconvulsive Therapy Accreditation Service (ECTAS) Accreditation
- Exceeded our target and achieved our highest ever uptake rate for flu vaccinations protecting our staff and service users from the flu virus
- Became a 'Smoke Free' Trust in September 2019 creating a healthier environment for our patients, visitors and staff
- Installed a new patient call system across inpatient facilities and completed a further phase of our Ward Refurbishment Programme
- Launched a new Trust Suicide Prevention Strategy encompassing a communication campaign and staff pledge to support a Zero Suicide Ambition, enhanced training to support use of safety plans for patients experiencing suicidal or self-harm thoughts and improved post event support for people bereaved by suicide
- Implemented a new standard of post discharge follow up within 72 hours of discharge
- Developed a structured debriefing process following disruptive and aggressive behaviour with a post incident process that includes service users
- Improved multi-disciplinary teamwork across Community Recovery Services
- Hosted a learning event promoted nationally to share good practice on use of Cognitive Stimulation Therapy
- Introduced Catheter Care Passports
- Launched a Hydration Awareness campaign targeting staff and patients to prevent healthcare associated Gram – negative bacterial bloodstream infections

- Established a Clinical Senate
- Trained our first facilitators to deliver Schwartz Round and Care Circles to support staff in the emotional and social aspects of caring for patients
- Delivered a Quality Improvement Programme in partnership with Black Country Partnership NHS Trust training upskilling staff in Quality Improvement Methodology whilst undertaking projects
- Trained a cohort of staff in Dementia Care Mapping to inform and improve services provided to people living with dementia.
- Exceeded targets of recruiting participants to 13 research studies undertaken by the Trust including observational, interventional studies and commercial trials and expanded its clinical trials pharmacy department
- Worked in partnership with stakeholders in Walsall to develop a Family Safeguarding Programme aimed at tackling challenges in safeguarding children through delivery of a service model that links agencies to work more closely with families where domestic abuse, substance misuse and mental health are known risk factors.
- Increased the number of Non-Medical Prescribers across services and launched a peer network for them to share learning and good practice
- Developed a group of facilitators to deliver the Forward Thinking Leadership programmes which will have a direct impact on equality, diversity and inclusion in the organisation
- Established Disability, BME and LGBTQ Staff Networks ensuring that staff members from protected groups, and other groups at potential risk of inequality, are enabled to develop a meaningful voice into the organisation.
- Recruited 5 Cultural Ambassadors and have developed a standard operating procedure, which will ensure fairness in how BME staff are treated

1.5 People and Relationships

1.5.1 *Involving and listening to our service users and carers*

As a provider of services, we are committed to ensuring that representatives of those people who use our services and their carers' are fully integrated within our decision-making and governance structures.

On a day-to-day basis, we work closely with a wide range of service user and carer organisations across the two boroughs, seeking their views and ensuring their participation in the planning and delivery of services.

Understanding patient experience is important to the Trust in order to ensure that our services are developed and improved to meet service users' needs through listening to peoples' experiences and views, responding comprehensively to feedback and demonstrating what has been improved as a result.

Here are some examples of how we engage service users and carers in our work:

- Experts by Experience (EBE) - An EBE is an expert volunteer who uses their experiences of mental health services, as a service user or a carer of someone with mental health problems, to influence the delivery and quality of services we provide. They also help represent the interests and views of other local service users and carers. We currently have 7 EBEs with each EBE bringing different skills and experience to the role to enhance the experience of services for our patients and carers
- Our Members – We have now recruited and retained over 7000 members - a proportion are service users and carers. By continuously engaging and involving our members we are becoming more accountable to our service users, carers, staff and the general public and can offer local people the opportunity to have a more direct influence on the way the Trust operates and develops. We send out various communications, such as surveys, invites to events, other information from stakeholder
- Youth Engagement – We regularly engage with young people through our CAMHS services gaining their feedback and input into service development. We also held a session with CAMHS service users to feedback on the development of the Trust website and refreshing imagery and branding for our merged trust.

- Supporting and listening to our carers - The Trust signed up to the Triangle of Care initiative which is a programme that aims to improve support and information for carers and as recognition of carers as key partners in care. The Trust received a Gold star in recognition of the progress we have made within inpatient services. We are now working towards our second Gold star for achieving the criteria across our community services.
- Patient stories - Patient stories are shared with Trust Board on a quarterly basis. The process involves asking patients or carers about their experience of using Trust services and on what improvements could be made. A breakdown of the challenges and positive outcomes from the story are shared with the Board.
- SED - Our Service Experience Desk offers advice and support to patients, service users, families and carers. They not only listen to concerns, comments and suggestions but receive compliments too. We have an online form and host drop-in sessions for people to share their concerns and ideas.
- Patient information - We work with patients to develop our patient information leaflets. Taking our leaflets to local mental health groups and forums to have their say on the information so that we receive detailed feedback prior to making the information public
- Surveys - Continue to encourage feedback on services through the Friends and Family Test, community and inpatient mental health surveys and service specific surveys. We are also implementing Patient Reported Experience Measures (PREMs) across the organisation, which are used to understand service users' views on their experience while receiving care. A standard set of core questions has been developed that are linked to the CQC's CREWS domains and will be asked in every service area to explore in more depth the experience across our services, to highlight areas of good practice and any potential areas for improvement.
- Recovery stories – we have worked with service users to articulate their story of recovery – we use recovery stories to describe an individual's journey of recovery to help inspire hope in others
- Engagement events - Inviting local groups and organisations to take part in Trust stakeholder event/workshops to help us plan for the future provision of mental health services in Dudley and Walsall
- Local service user and carer groups - We work with local groups and organisations to engage with service users and carers, to disseminate information and obtain feedback about Trust services, such as Healthwatch, Rethink Mental Illness and peer support groups
- Development of peer support in Inpatient Settings – EBEs secured £10,000 from Awards for All (National Lottery) to provide mentoring and befriending via peer support sessions and activity groups for service users admitted within the acute mental health wards at Dorothy Pattison Hospital and Bushey Fields. The project will provide emotional support to service users during their hospital stay by building self-esteem and confidence and reducing isolation, with the overall aim of enabling service users to achieve sustainable reintegration into the community, empowering them to lead more independent lives and leading to a meaningful recovery. The peer support project will be incorporated into the Therapeutic Hub and this will be built into the Therapeutic Hub Operational Policy.

1.5.2 *Our Staff*

We support a culture that is based upon working openly and collaboratively to provide high quality services that put the experience of our service users at the heart of all that we do.

Around 1100 staff work for the Trust, the majority of whom are clinicians and “front-line” staff. They are our most important resource and without their dedication, we would not be able to provide the services that we do.

Communication is central to every organisation. When used effectively it supports the creation of a positive working environment, cements working relationships with internal and external stakeholders and sets the tone for the entire organisation.

We recognise that building a culture of two-way communication, is crucial in helping to ensure that staff feel recognised and valued. In order to develop and maintain effective communications, the Trust will promote a culture that

- Is open, transparent and clear
- Encourages staff to suggest new ways of working
- Supports constructive feedback

Throughout 2019/20 we continued to strengthen how we communicate and engage with staff which has increased involvement and positive feeling amongst colleagues. Some of the highlights this year include our highest ever number of entries for our staff recognition Recognising Success Awards, ran 'Joy to the Wards' a staff gift donation campaign aimed at spreading some Christmas cheer on the wards and launched our Engagement Partner volunteer network – supporting staff throughout the merger and beyond.

We have also built our social media presence producing more video content and creating a closed staff Facebook group preparing for the merged trust where we post regular updates and other relevant content. Over 1000 staff members from both Dudley and Walsall Mental Health Partnership NHS Trust and Black Country Partnership NHS Foundation Trust have joined and it is continuing to grow. Across the Trust there are a number of ways in which we engage and communicate with our staff including:

- **Ask the CEO** - A dedicated mailbox set up to encourage staff to email the Chief Executive any questions they may have
- Refreshed our **Team Brief** sessions encouraging more interactivity and dedicated sections including local and national news, things you need to know, feedback from the previous month and spotlight on a particular topic or service.
- Refreshed our weekly ebulletin Wednesday Wire to include regular wellbeing and discount offers for staff.
- **Weekly email from CEO** – The Chief Executive sends a regular Friday email to all staff focusing on key updates for staff.
- **Freedom To Speak Up Guardian** – Continued promotion of the F2SU role and we also ran an internal and external campaign highlighting some of our work around this agenda. In addition, the Trust was shortlisted for a HSJ Awards for its work around Freedom to Speak Up
- We refreshed our engagement champion agenda looking to when we merge with our partners and launched **Engagement Partners** across both trusts
- **Staff Engagement Lead** – the Trust has a staff engagement specialist to ensure due attention is offered to the staff and their engagement, such as running focus groups and creating an action plan, agreed with the Trust's Board
- **Workplace Advisors (WPAs)** to offer staff resources / avenues to take if they have any issues
- A formal **Staff Partnership Forum** comprising recognised trade unions and other professional groups
- **On Board** - regular sessions which enable members of the Board to get out and about across all of our sites
- **The Exchange** –intranet for staff to access information on every aspect of Trust business
- **Active Desktop** – focussed messages which appear on the desktop of all Trust computers and are seen by all users every time they login
- A **Twitter and Facebook** account where the public and staff can keep up to date with news. This year we also launched a Trust Instagram account utilising more photo/video content
- The Trust has set up its own **You Tube** page where staff and the public can watch video content
- A **LinkedIn** page where we promote jobs across the Trust and key news stories
- **Staff Friends and Family Test** – careful analysis of these results is undertaken after each survey is completed, which has helped see a significant improvement in staff that would recommend the trust as a place to work or for treatment to friends and family

1.5.3 *Staff Health and Wellbeing*

The wellbeing of our staff continues to be of paramount importance to us as we recognise that this has a direct impact on clinical outcomes and the experience of patients. It is therefore important that our staff feel energised, motivated and healthy.

The Trust operates a bi-monthly Health and Wellbeing Committee who meet to discuss and plan operational health and wellbeing activities and programmes for staff. The group currently includes Human Resources, operational managers, Occupational Health and the Trust's Freedom to Speak Up Guardian/Staff Engagement Leads, although ultimately any member of staff regardless of base or level is encouraged to attend and contribute their opinions within the group.

This group reports directly to the Trust's workforce committee and also monitors CQUIN targets and associated action plans.

Over the last 12 months the Trust has undertaken targeted wellbeing activities and signposted information and services linked to World Health Organisation Awareness Days. This included a Trust-wide Step Challenge for staff across the month of May for National Walking Month and a Dyslexia Awareness Campaign during the awareness week in October.

Previous to the last 12 months the Trust had been successful in gaining a dedicated budget for Staff Health and Wellbeing. As part of the budget a business case was approved for a dedicated resource to lead on the Staff Health and Wellbeing agenda. The Workplace Wellbeing Co-ordinator commenced in post in January 2019 on a 12 month fixed term contract. As an example of the Trusts commitment to Staff Health and Wellbeing, this was extended to a full-time, permanent post.

The Trust has also been reviewing a range of benefits that can be offered to staff as part of staff wellbeing but also linking into the Trust's recruitment and retention strategy. During 2019/20, the Trust put in place an agreement with Vivup which included a host of discounts and offers, including schemes through Salary Sacrifice for staff. The schemes will be managed via an online, fully-editable wellbeing Vivup platform that all staff are able to sign-up to for free.

Staff also have access through Viv-up to an Employee Assistance Programme (EAP) which will provide all employees with a 24 hours advice and support line covering a range of wellbeing advice options and signposting to relevant NHS, 3rd sector and voluntary services. This alongside a face-to-face Staff Support service has provided an offer to staff for flexible counselling options, while we have also sent out regular communications informing staff of local and national support services they may have access to in this area.

Other notable achievements over the last 12 months include allowing staff free access to a gym on Trust premises, arranging Mindfulness groups who have also delivered taster sessions to away days and team meetings, providing 30 staff members with 12 weeks of free Slimming World vouchers, and setting up Workshops around Health & Wellbeing topics for staff to attend, and Staff Roadshows with the main focus on Wellbeing. The Trust used physical activity to build togetherness and generate healthy competition, organising the aforementioned Step Challenge, a Park Run Challenge, Charity Football Match, Staff Cricket game and staff have started their own Netball team which competes in a weekly league.

Over the next 12 months; Black Country Healthcare NHS Foundation Trust will have a lot more staff to reach out to, and will look to build awareness for staff to the initiatives and support available for their wellbeing, combining the excellent work done previously across both BCP and DWMH. Part of this method to build awareness will be to create a social media presence, introducing an official Health Champion scheme, updating the information accessible online to staff and offering a session that can be rolled out as part of team away days. We also want to cover more wellbeing topics as part of our Workshops and create more promotion to staff of information around World Health Organisation Days. Importantly, an increasing part of Health and Wellbeing support over the last few months has been reacting to individual or team cases, and we will continue to support staff as much as we can with any cases that impact on wellbeing.

Covid-19 has had a huge impact on us all, and its impact required both immediate health and wellbeing intervention, but also plans to be put in place for the long-term holistic support for staff wellbeing. At the time of writing, some of the projects worked on included daily communications and updates to staff, a guide/toolkit to advise on how best look after their well-being and providing a wide range of resources to access, a collection of psychological support including counselling, CBT and virtual care circles, a wellbeing checklist for managers to support themselves and staff including a tool to use in supervisions, and creating rooms for staff to go to when needing to break away from stressful situations and by improving staff facilities.

The Trust made effective use of social media using a staff space page to share positive messages, continually update staff including the Chief Exec Q&A, videos to benefit staff such as yoga and PT sessions, and signposting to offers and discounts which were continually offered to staff by services in the community looking to reward the hard work across the NHS during the pandemic. The Trust also contributed use of one-to-one counselling and use to the Silvercloud app, making this available to staff working in care across the region.

This work will continue to develop, with additional focus looking at long-term wellbeing advice including for those working in different settings including from home, those staff who suffer due to the trauma experienced during the pandemic, staff that may be affected by bereavement, and by continuing to adapt and react to the challenges the pandemic brings.

1.5.4 Involving other stakeholders

The Trust continues to focus on developing meaningful relationships with its wider stakeholders ensuring they are kept up to date with Trust developments and providing them the opportunity to influence the delivery of services. Over the year the Trust has participated in national and local events including a joint STP launch of the Black Country Community Perinatal Service, we hosted a specialist older adult cognitive stimulation therapy conference sharing learning with colleagues from across the country and we have also inputted into Black Country-wide level work around suicide prevention.

Below are some of the activities we have undertaken during the year.

Figure 7 Stakeholder engagement

Commissioners	<ul style="list-style-type: none"> • Attended local Mental Health Programme Boards • Hosted monthly Contract Review Meetings and quarterly Quality Reviews • Worked in partnership to develop services and pathways and address gaps and inconsistencies in service provision • Worked closely with CCG communications teams to support local initiatives such winter campaign, long term plans and place-based care
GPs / referrers	<ul style="list-style-type: none"> • Engagement with GPs and commissioners on the development of place based models of care in Dudley • Highlighted relevant GP information via CCG communications channels • Created a GP resource page on our website • Clinicians attend regular forums providing education and input to GP Forums
Media	<ul style="list-style-type: none"> • Continued to develop relationships with local media responding to enquiries and proactively promoting news • Built on our national and regional profile. Alongside many positive news articles in local press including features on our employment services and talking therapies
Members and the public	<ul style="list-style-type: none"> • Member emails highlighting Trust updates and events • Held an information and advice fair as part of the AGM including stalls from partners • Supported a number of national campaigns throughout the year including Mental Health Awareness Week, National Apprenticeship Week and LGBT and Black History Month

Local NHS providers, public sector / third sector organisations	<ul style="list-style-type: none"> • Attending local events to promote services • Utilising partners communication networks to promote services / service developments
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We continue to develop relationships with stakeholders with an emphasis on encouraging two-way communications and engagement. Over the coming year there will be a continued focus on strengthening partnership working. Central to the success of this will be engaging with stakeholders.

1.5.5 *Valuing, Equality, Diversity and Inclusion - creating a personal, fair and diverse NHS*

The Trust is committed to a culture where those working for us are valued and appreciated for the skills and talents they bring to the organisation and where the needs of those using our services are understood and respected. We are committed to treating everyone who visits or works for us with respect and as individuals, taking into account their individual differences, personal values and perspectives.

In addition, the Trust's commitment to equality, diversity and inclusion continues to be recognised by NHS Employers with whom we meet regularly to report on our work and to learn from the successes of other NHS organisations. We also continued to try new ways of engaging and supporting diverse staff and communities, particularly through the BME, Disability and LGBTQ+ Staff Networks.

During 2019/20 the Trust has continued to fulfil its mission to embed equality and inclusivity throughout the organisation to enable the Trust to excel in equality, dignity and diversity practice. Tackling inequality and removing barriers in respect of equality, diversity and human rights through employment and the services provided remains a key strategic focus for the Trust.

Our commitment to ensuring Equality, Diversity and Inclusion within our workforce is essential to ensure that we deliver safe, caring and excellent services in line with our Trust values.

The importance of inclusion is embedded into the Five Year Forward View (FYFV); NHS Long Term Plan (LTP) and the recently published People Plan as well as highlighted quite prominently in the Developing People; Improving Care framework. All of these key documents identify how important it is that inclusion is integral to any and all activities to ensure we provide the best health and care services to the diverse communities we serve across Dudley and Walsall.

Trust's successes and achievements:

The Trust has successfully completed the following actions to meet its Public Sector Equality Duty (PSED) compliance:

- Equality Delivery System (EDS) and Equality Objectives – The Trust continues to progress with the EDS2 implementation action plan and has successfully achieved progress against the Trust's 4 equality objectives
- Equalities Information Data - the Trust published its equalities data on the 31st January 2020
- Workforce Race Equality Standard (WRES) – Continued to implement the requirements of the WRES and deliver on the 2019/20 Action Plan
- Accessible Information Standard (AIS) – Continued to implement the requirements of the AIS in engagement with staff and Expert by Experience service users and carers
- Workforce Disability Equality Standard (WDES) – The Trust reported year 1 data for the WDES in August 2019
- Equality Impact Analysis (Assessments) – Continued to carry out EqIA's for policies, procedures and service development areas

- Cultural Ambassador Programme – The Trust continues to implement the Cultural Ambassadors programme and the CA's have been successful in reducing the number of BME staff going through the disciplinary process.

Supporting staff with disabilities

We are committed to supporting staff that have a disability or become disabled during the demonstrating that we meet the standard to encourage and make adjustments for applicants with disabilities, and to guarantee an interview to those who meet the person specification for the post.

We also actively support staff with both physical and mental health needs and have a robust Occupational Health and Staff Support service. The Trust is a certified Disability Confident Employer.

The Trust is signed up to the Mindful Employer Charter. The Charter for Employers who are Positive about Mental Health is a tangible display of commitment to improving the working lives of staff.

All Policies are equality Impact assessed to ensure that there is no adverse impact on staff who may have a disability or if a disability should arise.

Staff Networks

To support us to deliver our commitment to equality, diversity and inclusion the Trust established three staff networks, BME, Disability and LGBT chaired by members of staff. Through these networks staff have a voice and means to ensure that the experience of our staff and service users is positive and inclusive.

1.6 Sustainability

During 2019/20 there has been continued progress in the delivery of the Trust's Sustainability Strategy. The key achievements are:

- Planning the proposed new build at DPH aspires to the BREEAM excellent standard (an assessment using scientifically based sustainability metrics and indices that covers a range of environmental issues. Its categories evaluate energy and water use, health and wellbeing, pollution, transport, materials, waste, ecology and management processes).
- Ensuring all capital schemes comply with latest guidance regarding use of sustainable materials. For example only using timber sourced from sustainable sources
- Using LED light fittings as a replacement standard.
- Continuing to invest in upgrading of Building Management System to all Trusts premises
- Staff are actively encouraged to recycle / reuse various items not only within their own team, but also across the Trust; items include stationary, print consumables, furniture etc.

The Trust recognises the importance of their contribution in promoting sustainable development in order to reduce emissions, save money and improve the health of people and communities as it works towards the 34% reduction target for 2020.

Looking forward, the Trust will consider as part of its refreshed strategy opportunities to refresh our sustainable development strategy, including the use of a Salix grant, interest free finance to:

- Refresh our sustainable development strategy, including:
- Review of Trust Board approved Policy
- Explore specialist services to support the Trust in this work, whilst also considering if other opportunities may be viable through our new strategic partnerships

1.7 Health and Safety

The Trust is committed to providing a healthy and safe environment for service users, visitors and staff, at all Trust properties.

During 2019/20 Health and Safety Advice and Training was supplied under contract by Bradley Environmental, and Fire Safety Advice and Training was supplied under contract by STK Fire and Risk Management Ltd.

Both companies provided the services of dedicated Health and Safety and Fire Safety advisors to the Trust, and ensured the Trust met and achieved a high standard of Health and Safety and Fire Safety.

The Trust regularly updates its Health and Safety and Fire Safety processes. An example of this is to incorporate any new relevant guidance issued from the Health and Safety Executive (HSE) into existing policies or create new policies and procedures.

During 2019/20 the main focus for fire safety has been embedding the improvements made to the Trust processes and redesigning the way inpatient training is delivered to enable staff to be able to interpret training to their work environment.

The aim is to ensure that every person within the Trust has an awareness of safety in all that they do and whomever they work with.

To ensure the Health and Safety and Fire Safety of all persons who frequent the Trust, the following areas of Health and Safety and Fire Safety work are carried out regularly:

Property

- Full Annual Health and Safety audits are carried out by the Health and Safety Advisor to ensure Health and Safety standards are maintained.
- Quarterly Health and Safety audits are carried out by Ward and Office based staff.
- The Fire Safety Advisor carries out annual inspections of all Trust sites.
- The Fire Safety Advisor also carries out monthly walk round inspections of all Hospital sites.
- The results of these inspections and audits are reported to the Estates department for any remedial work. These reports are also presented to Trust Health and Safety Committee who meet on a bi-monthly basis.

Training

Training is delivered to all staff to underpin this, both through H&S training and Link Worker training to encourage staff to volunteer to be H&S Ambassador's.

A new format of Fire Safety Training for all inpatient staff that incorporates "Tabletop Evacuation" training was started in 2019.

To underpin the managerial responsibility and leadership, Trust staff have received their mandatory Health and Safety and Fire Safety training.

Incident investigations

All Health and Safety related incidents are reported via an online incident reporting system. The Health and Safety Advisor monitors all Health and Safety related incidents and carries out investigations where required.

RIDDOR

To ensure compliance with the requirements of "The Reporting of Injuries, Diseases and Dangerous Occurrence Regulations" (RIDDOR), accidents and incidents are reported (when required) to the HSE. In the last year there have been 3 incidents reported to the HSE.

HSE Inspectors

The Trust has not received any notices of Improvement, Prohibition or Enforcement from the HSE or the Care Quality Commission (CQC) in relation to matters of Health and Safety.

1.8 Planning for the Unexpected

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This could be anything from extreme weather conditions to infectious disease outbreak or a major transport accident or terrorist attack. This work is referred to in the health service as “emergency preparedness, resilience and response” (EPRR) and is underpinned by legislation contained within the Civil Contingencies Act and the NHS Act 2006 (as amended) and the NHS Standard Contract.

Emergency Planning stems from the National Security Risk Assessments and the local Community Risk Register. To support these assessments, National Business Resilience Planning Assumptions set the standards we have to work to in mitigating those risks. This builds a requirement for us to produce specific emergency plans to react to incidents involving those risks.

As a specialist mental health Trust, our statutory role is to be able to respond to internal and external incidents, supporting other health economy organisations and other 'Responder' organisations as identified in the Civil Contingencies Act. As part of our internal arrangements, we must have the ability to respond 24/7 to any incident and must maintain a suite of emergency and business continuity plans, embedding emergency planning as a culture within the organisation. The on call roles are currently being reviewed and rationalised across the organisation.

Under the Civil Contingencies Act 2004 (CCA), there is a statutory requirement for all NHS organisations categorised as Category 1 or Category 2 responders to have appropriate emergency planning and business continuity arrangements in place.

This means that the focus for the Trust is on developing and embedding appropriate business continuity arrangements to ensure it can effectively meet the challenges of incidents that can disrupt the continuity of its critical and essential services as described by the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

The minimum requirements, which providers of NHS funded services must meet, are set out in the current NHS England Core Standards for EPRR. The standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended).

The NHS Standard Contract Service Conditions require providers to comply with the EPRR guidance. Therefore, commissioners must ensure providers are compliant with the Core Standards as part of an annual assurance process.

To monitor compliance, the Trust must assess itself against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) on an annual basis and submit the assessment to both NHS England and the CCGs. Following the Trust merger, legacy plans are being reviewed and rationalised ahead of the Core Standards self-assessment for 2019/2020.

Business Continuity is about maintaining our ability to deliver prioritised services during a critical incident or emergency situation e.g. a major security incident or an influenza pandemic. Effective Business Continuity Management is therefore about the identification, management and mitigation of particular risks to our ability to deliver these essential services. The Trust has a Business Continuity Management Policy and associated Business Continuity Plans to meet this need. These are currently being reviewed in a comprehensive business continuity audit.

The model adopted accords with the best practice expectations placed upon all NHS organisations in the NHS England Business Continuity Management Framework (service resilience) 2013 and the associated requirements listed in the NHS England Core Standards for Emergency.

The BCM policy describes the strategic framework of how the Trust manages its business continuity planning. The Strategy is currently being reviewed following the merger, and to bring it in line with current ISO guidance.

In addition to emergency and business continuity planning, the Trust Risk Register is being aligned to the local health economy and EPRR risk register to capture emerging health and multi-agency risks to the organisation. The Trust is also introducing a comprehensive debrief model to capture learning and good practice following incidents and disruptive events, building those into a corporate Lessons Register.

A comprehensive new training and exercising programme has been created to increase knowledge and understanding of emergency planning and how key role holders within the organisation can effectively contribute to service delivery, response and recovery during a major incident. Training will be a continual ongoing cycle of learning and will be reviewed annually. Exercising will follow a 3 year programme covering all delivery models, culminating in a live exercise in 3 years' time in line with statutory requirements.

1.9 Key strategic risks / issues

The Board Assurance Framework included six strategic risks, these are outlined below. There is one additional risk from the previous year related to the merger with BCPFT.

Figure 8 Strategic risks

RISK REFERENCE	Risk Description
SR1	Sustainability of the Organisation
SR2	Long term financial sustainability
SR3	Achieving quality of care
SR4	Ability to recruit and retain staff
SR5	Management, Maintenance and Strategy for the Estate
SR6	Impact of the BCP / DWMH Integration on the ongoing delivery of services

1.10 Our 2020 / 21 Plans

The year has been pivotal for our Trust and for mental health services in general culminating with the successful merger to create Black Country Healthcare NHS Foundation Trust, a platform to create the highest quality mental health, learning disability and children's service provision across the Black Country.

Our merger has been a major focus throughout the year in order for us to harness the opportunities that bringing together mental health and learning disability services across the Black Country offers.

The NHS ten year plan brought with it a significant shift in focus for our services along with considerable investment with which we are able to ensure that more people receive the care they need at the right time and in the right place. Despite the challenges of covid-19 we expect this to remain a priority for the NHS and for us.

The covid-19 pandemic has inevitably reshaped our focus for the year ahead as a merged Trust and is bringing much learning, opportunity and change. Our focus for the year ahead is aimed at learning from our experiences of the pandemic to reap the benefits of this across our services and within our communities. As a merged Trust we have a great opportunity to reimagine mental health and learning disability services for the Black Country.

Black Country Healthcare NHS Foundation Trust's plans for 2020 / 21 will therefore focus on the following:

- Ensuring a successful integration of services post-merger
- Harnessing the learning from Covid-19
- Build on excellent engagement to allow our members, governors and service users more opportunity to shape mental health and learning disability services as we implement our recovery planning
- Delivering the NHS LTP priorities in partnership with our STP, providing more services locally for our communities
- Playing our part in delivering place based system reform for mental health
- Continue to foster a culture of openness and transparency for staff and service users

The new Dudley Integrated Health and Care NHS organisation will focus on the following:

- Developing the Talking Therapy and Primary Care Mental Health services building on the existing solid foundations
- Completing the final stages of the process to be awarded the Integrated Care Provider contract for the Dudley Population

Our annual plan will describe our approach to delivering our priorities for the forthcoming year and the synergy with our STP and other local partnerships. Due to Covid-19, the annual planning process has been deferred until later in the year, that does not however mean that we are not working towards our new organisational objectives and we will update our stakeholders regularly.

2 Performance Analysis

2.1 Managing Trust Performance

Over the course of 2019 / 20, we have continued with the use of OASIS and PC-MIS and the data warehouse which has enabled high quality Business Intelligence to be used to inform strategic and operational decisions at all levels of the organisation.

The key achievements for Performance and Information for 2019/20 include to:

- Enhanced Business Intelligence reporting Hub
- A clinical coding audit concluded was maintaining a good standard of clinical coding accuracy
- EPR commencement following sign off of strategy and business case by the Trust Board
- Continuing the delivery of extensive data quality project actions to enable accurate reporting across a wide range of metrics including national, local and service transformation quality indicators

Black Country Healthcare NHS Foundation Trust's key aims for Business Intelligence and Performance 2020/21 will include:

- Aligning performance and information reporting for the new Trust, Black Country Healthcare Trust
- Complete new EPR system implementation
- Develop and update the Performance report to reflect 2020/21 contractual Key Performance Indicators (KPI), specifically focussing on national KPI metrics during the first half of the year.
- Produce Trust information submissions to reflect all statutory returns, such as Mental Health Service Data Set (MHSDS)
- Produce the Adult Community and Inpatient Benchmarking for the Benchmarking Network and others where appropriate
- Prepare the Community survey and the patient dataset Quality Health
- Maintain full compliance with the Data Security Standards

2.2 Measuring the standards of our service

We have continued to make improvements to our performance management and reporting framework in 2019/20 and these changes have led to the availability of more timely and accurate data at all levels, as well as improved clinical engagement through performance information. To support real-time, flexible reporting of performance and support of business decision making, we have enhanced the suite of reports available via the BI Hub to front line services.

The Trust reports on all key performance metrics to the Contracted Activity and Review Meeting (CARM) and the Finance and Performance Committee (F&P). The F&P Committee is held during the year, chaired by a Non-executive Director, with another Non-executive Director, Trust Chief Executive, Director of Finance, Performance and IM&T and Director of Operations, Nursing and Estates in attendance.

The Trust reports monthly to Dudley and Walsall Commissioners through monthly contract review and clinical quality review meetings on achievements against a suite of Contractual Key Performance Indicators (KPIs) and Quality Improvement measures. These meetings are attended by Commissioners, the Contract Manager, the Associate Director of Nursing and the Associate Director of Operations.

A performance report covering the following key areas of performance is reviewed at the monthly Contracted Activity Review Meeting and the Finance and Performance Committee:

- Month on month activity, together with analysis and comparison of activity levels in previous years
- Month on month performance against contractual KPIs
- Month on month performance against National Measures Indicators
- Month on month performance against internal Service Transformation Quality Indicators
- Data quality improvement

2.2.1 Performance Dashboard 2019/20

The Trust manages and monitors indicators at all levels across the Trust. An Integrated Performance Dashboard example is shown giving the trends over the last 18 months.

Figure 9 Month 12 Performance Dashboard

Integrated Trust Performance Dashboard 2019/20 Month 12						
Quality and Safety						
Indicator	Period	Target	Actual	RAG	Exception	Trend
7 Day Follow Up on Inpatient Discharges	YTD	95%	97.71%	G		
CPA - Review in 12 months	YTD	95%	94.40%	A	Q1	
CPA – Copies of Care Plans	YTD	95%	90.33%	A	Q2	
Delayed Transfers of Care (all reasons)	Monthly	<7.5%	2.66%	G		
Never Events	YTD	0	0	G		
Percentage of Patient Safety Incidents categorised as resulting in moderate, severe harm or death	Monthly	<3%	0.70%	G		
Serious Incidents	Monthly	<4	3	G		
Falls Resulting in Severe Injury/Death	Monthly	0	0	G		
Grade 3 or 4 Pressure Ulcers (whilst in our care)	Monthly	0	0	G		
MRSA Bacteraemia	Monthly	0	0	G		
Mixed Gender Breaches (Wards)	Monthly	0	0	G		
Trust Compliance Rate	Monthly	Between 90-120%	109.93%	G		
Staffing Rate - Day RMN	Monthly	Between 90-120%	107.96%	G		
Staffing Rate - Day HCA	Monthly	Between 90-120%	96.44%	G		
Staffing Rate - Night RMN	Monthly	Between 90-120%	85.35%	A	Q3	
Staffing Rate - Night HCA	Monthly	Between 90-120%	115.81%	G		
Service User Experience						
Indicator	Period	Target	Actual	RAG	Exception	Trend
Friends and Family Test - % of Promoters (CQUIN)	Monthly	70%	66.69%	A	S1	
New Complaints	Monthly	13	13	G		
New Concerns	Monthly	23	25	A	S2	
% Complaints/Concerns regarding Care/Treatment	Monthly	80%	27.00%	A	S3	
Compliments (Month)	Monthly	35	28	A	S4	
Response Breaches	Monthly	30%	35.29%	G		
Data Quality - National Reporting						
Data Quality	Data Period	Trust Value	National Median	CQUIN Q4	Exception	
Data Quality Maturity Index	Dec-19	91.42%	79.90%	95%	D1	
Efficiency						
Indicator	Period	Target	Actual	RAG	Exception	Trend
Out of Area Placements (Bed Days)	Monthly	TBC	0			N/A
Bed Occupancy (Inc Leave)	Monthly	86%	83.21%	A	E1	
Bed Occupancy (Exc Leave)	Monthly	75%	76.25%	G		
EIP Access Rates	Monthly	56%	66.67%	G		
Memory Assessment Service - F2F assessment within 20 days	Monthly	95%	64.71%	R	E2	
IAPT - people receiving Psychological Therapies (Dudley)	Monthly	624	459	R	E3	
IAPT - people receiving Psychological Therapies (Walsall)	Monthly	529	417	R	E4	
IAPT - people who have successfully completed treatment and are moving to recovery (Dudley)	Monthly	50%	41.26%	R	E5	
IAPT - people who have successfully completed treatment and are moving to recovery (Walsall)	Monthly	50%	42.31%	R	E6	
Eating disorders - % of CYP who receive treatment within four weeks for routine cases	Monthly	95%	100.00%	G		
Eating disorders - % of CYP who receive treatment within one week for urgent cases	Monthly	95%	100.00%	G		
Number of Contractual Performance Notices	Monthly	0	0	G		N/A
Resources						
Indicator	Period	Target	Actual	RAG	Exception	Trend
Liquidity Ratio (days)	Monthly	1	1	G		
Capital Servicing Capacity (times)	Monthly	1	1	G		
I&E Margin Rating	Monthly	1	1	G		
I&E Margin Variance from Plan	Monthly	1	1	G		N/A
Agency Metric	Monthly	2	2	A	R1	N/A
CIP Against Plan (FYE of Delivery)	Monthly	£2,133	£2,050	R	R2	N/A
Income Against Plan (E000)	YTD	£78,308	£79,085	G		
Performance against Budget (E000)	YTD	N/A	£33	G		N/A
Cumulative Agency Spend as a % of Total Employee Benefits	YTD	6.77%	5.92%	G		
Vacancy Rate	Monthly	10.00%	6.23%	G		
Turnover - Rolling 12 Month	12 Month Rolling	10-13%	10.73%	G		
Sickness - in Month	Monthly	4.68%	4.29%	G		
Sickness - Rolling 12 Month	12 Month Rolling	4.68%	4.66%	G		
Appraisals	Monthly	85%	82.13%	A	R3	
Mandatory Training (Aggregated)	Monthly	90%	88.72%	A	R4	

2.3 Quality and Safety

2.3.1 *Managing the Quality of our services*

All staff working within the Trust has a duty to ensure the delivery of high quality, safe, effective and person centred services, which are continually reviewed, monitored and improved. Quality is at the heart of everything that we do and is rooted in our core values and culture of openness and transparency.

The Trust's Quality and Safety Committee has overarching responsibility for patient safety and quality and for the monitoring and assurance of quality performance. Underpinning this Committee's function are service line Quality Groups and Clinical Quality Review Meetings that are held with commissioners.

The Trust has an established, yearly process for identifying quality priorities based on intelligent data and risk profiles, from which targeted quality improvement plans are developed. The quality improvement plans set out measures of success and objectives, and are delivered through a project management approach. Monitoring of the implementation and impact of projects is via quarterly reports to the Quality and Safety Committee.

An annual Quality Account is produced by the Trust that sets out its quality priorities and then reports on outcomes in delivering these. This Account is subject to scrutiny by commissioners, Health Overview and Scrutiny Committees, Health Watch, Experts by Experience and service users. This forms crucial assurance with regard to evidencing the Trusts track record of embedding quality outcomes. The Trust is working to revised deadlines for publication of its 2019/20 Quality Account in line with national guidance in response to Covid-19.

The Trust continues to embed a positive culture of learning lessons and has adopted national guidance on 'Just Culture' to support learning and continuous improvement. Integral to this are 'embedding lessons meetings' a key governance process, linked to risk management and incident reporting policies, that facilitate learning, sharing and implementation of key lessons following serious incidents across all service lines. This is delivered through the Trust's Embedding Lessons procedures which are supported by Trust-wide Embedding Lessons and Triangulation meetings which aim to review data from various quality governance sources (e.g. complaints, incidents, audit, experience surveys, staff surveys and safeguarding) in order to identify wider learning opportunities and ensure a robust response to themes in learning.

The Trust Board remains committed to fully embedding Quality across the Trust and continues to undertake self- assessments against the Well-Led Framework which reviews the Quality and Corporate Governance arrangements of the Trust. The Well-Led Framework outlines key governance questions referencing good practice and how the Trust evidences compliance with the following:

- The Board having a credible strategy and robust plan to provide quality, sustainable services to patients and aware of the potential risks to the delivery of current and future services
- The Board having the skills and capability to lead the Trust, with an open, transparent and quality focused culture, supporting continuous learning and development
- Clear lines of accountability in relation to Board and Quality Governance, with defined processes for escalating and resolving issues and managing performance
- The Board actively engaging patients, staff and other key stakeholders on quality, operational and financial performance
- The appropriateness of information on organisational and operational performance being that is being analysed and challenged and the effective use of quality information

2.3.2 Quality Dashboard

The Trust manages and monitors the following quality improvement indicators at all levels across the Trust. A Quality and Safety Dashboard example is shown giving the trends over the last 18 months.

Figure 10 Month 12 Quality Dashboard (snapshot from Integrated Performance Dashboard)

Quality and Safety						
Indicator	Period	Target	Actual	RAG	Exception	Trend
7 Day Follow Up on Inpatient Discharges	YTD	95%	97.71%	G		
CPA - Review in 12 months	YTD	95%	94.40%	A	Q1	
CPA – Copies of Care Plans	YTD	95%	90.33%	A	Q2	
Delayed Transfers of Care (all reasons)	Monthly	<7.5%	2.66%	G		
Never Events	YTD	0	0	G		
Percentage of Patient Safety Incidents categorised as resulting in moderate, severe harm or death	Monthly	<3%	0.70%	G		
Serious Incidents	Monthly	<4	3	G		
Falls Resulting in Severe Injury/Death	Monthly	0	0	G		
Grade 3 or 4 Pressure Ulcers (whilst in our care)	Monthly	0	0	G		
MRSA Bacteraemia	Monthly	0	0	G		
Mixed Gender Breaches (Wards)	Monthly	0	0	G		
Trust Compliance Rate	Monthly	Between 90-120%	109.93%	G		
Staffing Rate - Day RMN	Monthly	Between 90-120%	107.96%	G		
Staffing Rate - Day HCA	Monthly	Between 90-120%	96.44%	G		
Staffing Rate - Night RMN	Monthly	Between 90-120%	85.35%	A	Q3	
Staffing Rate - Night HCA	Monthly	Between 90-120%	115.81%	G		

2.3.3 Contractual quality requirement goals agreed with commissioners

For 2019/20, the Trust monitored 27 contractual Key Performance Indicators (KPIs). All of these metrics were either mandated nationally or negotiated locally with the host CCG's during the negotiation round.

The table below shows the performance levels achieved for the KPIs where thresholds were finalised in the year.

Figure 11 Contractual KPI's Performance in 2019/20

Contractual KPIs		Target	Achieved
1	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0
2	7 day follow up on Inpatient Admissions	>95%	96.7%
3	Delayed Transfers of Care (All Reasons)	<7.5%	1.8%
4	Copies of Care Plans (CPA caseload)	>95%	93.4%
5	Percentage of people experiencing a first episode of psychosis	>56%	67%
6	The proportion of people that wait six weeks or less from referral to their first IAPT treatment appointment	>75%	96.8%
7	The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment	>95%	98.3%
8	The proportion of users on CPA who have had a review within the last 12 months	>95%	95.2%
9	Proportion of in-scope patients assigned to a cluster	Dudley>95%	95.1%
10	IAPT– People who receive psychological therapies – attending one session only	Dudley>7014	Dudley - 5759
		Walsall>5700	Walsall – 4591
11	IAPT – people who have successfully completed treatment	>50%	Dudley – 49.4%
			Walsall – 50.1%
12	CRS - proportion of patients seen within 6 weeks.	Dudley>90%	95.1%
13	PT Hub - proportion of patients seen within 18 weeks.	Dudley>95%	96%
14	Eating Disorders - % of children & young people who receive treatment within four weeks of referral for routine cases	>95%	88.7%
15	Eating Disorders - % of children & young people who receive treatment within one week of referral for urgent cases.	>95%	90%
16	PLT - number of patients seen on the wards within 24 hours.	Dudley>85%	98.8%
17	PLT - number of patients seen in A&E assessed within 4 hours.	Dudley>95%	97.6%
18	Memory assessment first face to face contact within 20 working days	Dudley>95%	96.4%
19	Percentage of inpatient admissions that have been gate kept	Walsall>95%	100%
20	MHAS Proportion of Crisis Referrals seen within 4 hours	Dudley>98%	98.5%
21	ICAMHS: Where referral/intervention is to prevent possible Tier 4 admission, the crisis team will respond within a maximum 4 hours	Dudley>95%	96.7%

The Trust's overall performance against the commissioners' KPIs is very positive but has slightly decreased during Q4.

Significant improvements have been made in data quality and the Trust meets regularly with commissioners to discuss performance and quality.

The Trust is fully aware of areas it needs to improve and is working closely with commissioners to achieve this.

2.3.3 Quality Account Priorities

In 2019/20, we have continued to implement our second Quality Improvement Strategy 2016-2020 and promote a culture of on-going quality improvement throughout the services delivered.

In 2019/20, we set ourselves 4 quality account priorities; the table below shows the progress we made against these.

To ensure the priorities are mapped into the Trust Quality Governance Framework, a full quarterly update is provided to the Quality and Safety Committee, detailing progress and an overview of outcomes and exceptions.

Figure 12 Progress against our quality account priorities

Quality Improvement Priority	Description	Progress
Patient Safety First Approach	The Trust is committed to providing harm free care to patients; reducing and preventing any unintended or unexpected event that could lead to harm. This quality improvement priority has built on work undertaken during 2018/19 to improve safety culture and has driven actions to positively impact on delivering harm free care to patients. Its focus has been on reducing levels of harm as a result of disruptive and aggressive behaviour and falls.	<p>Completed a review of Personal Safety Training, revising content to reflect requirements highlighted through staff feedback and learning from incident reviews.</p> <p>Introduced an approach to structured debriefing to support consistency in post incident debriefing for staff and patients, now included in Management of Actual and Potential Aggression (MAPA®) training, reflected in policy documents and captured in incident records.</p> <p>Reviewed the evidence base and concept for use of body worn cameras within inpatient services with patients and staff. Plans to pilot this will be taken forwards in partnership with Black Country Partnership NHS Foundation Trust.</p> <p>Extended the use of Dementia Care Mapping across Dementia Care Wards to support delivery of person centred care, reducing behaviors that challenge and reviewed tools for use within Working Age Adult Inpatient settings.</p> <p>Completed actions to improve the culture of reporting low level incidents of disruptive and aggressive behaviour within Community services to better inform incident trend analysis and further improvement actions.</p> <p>Reviewed lone working practices within community services.</p> <p>Introduced Falls champions within Working Age Adult Inpatient settings to spread good practice in relation to assessing and mitigating falls risks.</p>
Suicide prevention	This quality improvement priority aims to reduce the number of suicides of known or recently discharged service users as well as to support a reduction in overall suicide rates across the Dudley and	Launched a campaign to raise the profile of suicide prevention and the Trust commitment to Zero Suicide Ambition, engaging staff to pledge support to the aspirational challenge of preventing suicide deaths of individuals under our care.

	<p>Walsall boroughs. It will drive actions to support the Trusts 'zero suicide ambition' on inpatient areas, in line with the Zero Suicide Alliance (ZSA) national programme.</p>	<p>Implemented a new standard of post discharge follow up of patients within 72hours of discharge.</p> <p>Established a multi-disciplinary steering group and trained facilitators to introduce Schwartz Rounds to support increased opportunities for staff to reflect on the emotional aspects of work.</p> <p>Extended staff training on suicide prevention through STORM and Connecting with People Training.</p> <p>Reviewed policy and practice in supporting those affected and bereaved by suicide and trained a cohort of staff in Postvention: Assisting those Bereaved by Suicide (PABBS).</p>
<p>Pathways and Transition</p>	<p>This quality improvement priority aims to review current maps of our clinical pathways and pathways themselves to ensure a format that is clear, accessible, and transparent to enable service users and stakeholders to navigate our services. It will be an enabler for planning combined Black Country Mental Health Services, models of place based care and implementing the Long Term Plan for Mental Health, building on the policy platform laid out in the <i>NHS five year forward view</i> (Forward View) which articulated the need to integrate care to meet the needs of a changing population</p>	<p>Conducted and evaluated a 6 month pilot for Walsall Place Based teams; lessons learnt are monitored through the community service line.</p> <p>Implemented pathways to support earlier follow up of patients, post discharge from hospital.</p> <p>Specialist Pathways are in development, the Trusts Adult Neurodevelopment Service team is currently expanding to incorporate the requirements of the Transforming Care Partnerships (TCP) programme to ensure a smooth pathway for patients who have autism.</p> <p>Commenced a programme of Outpatient Pathway development that supports effective, recovery focused outcomes. This work will continue through 2020/21.</p>

<p>Prevention and Recovery</p>	<p>Recovery is a concept that recognises people can be in control of their lives despite mental health problems, and can regain a meaningful life despite a mental illness. This quality improvement priority seeks to ensure our services optimise health and wellbeing by supporting evidence based intervention, personalisation and recovery. Its aim is to ensure all patients within DWMHPT are assessed and monitored using an identified clinical outcome tool recorded as part of the care plan which allows for greater involvement, better satisfaction and improved recovery in the treatment journey. In addition, the recovery movement has seen the introduction of peer worker roles that positively impact on increasing hope and engagement through the power of “having been there”. Hope is central to the belief required for people who face significant mental health challenges and forms an important part in supporting people’s transition into recovery. This quality improvement priority aims to drive the coproduction of peer support within our services.</p>	<p>Introduced ReQoI (Recovering Quality of Life) within its Inpatient Therapies Hub to measure reported outcomes of care.</p> <p>Scoped models for supporting the introduction of peer support roles and gathered learning from other organisations. The Trust is now piloting a peer support role within the Perinatal Mental Health service.</p>
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2.3.4 CQUINs

A proportion of the Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Dudley and Walsall Mental Health Partnership NHS Trust and the commissioners through the Commissioning for Quality and Innovation (CQUIN) framework. CQUIN is a national initiative which aims to embed demonstrable quality improvements within the commissioning cycle for NHS healthcare.

For 2019/20, the Trust participated in 7 national CQUIN schemes with a total value of **£761,759**. The schemes cover a range of services including the four quality domains of Patient Experience, Safety, Effectiveness and Innovation.

The CQUIN scheme indicators summarised below.

Figure 13 National 2019/20 CQUINs Schemes

Scheme Title	
1.	Staff Flu Vaccinations
2.	72 hour Follow up post discharge
3.	Mental Health Data Quality (A) MHSDS Data Quality Maturity Index
4.	Mental Health Data Quality (B) Interventions
5.	Preventing ill health by risky behaviours – alcohol and tobacco
6.	Use of Anxiety Disorder Specific Measures in IAPT
7.	D/deaf Communications Assessment

The Trust performed really well to achieve the majority of its CQUIN targets for 2019/20. This resulted in a marginal under performance against the CQUIN income target for 2019/20. This under performance was not recovered by the host CCGs in recognition of the Trust's significant over performance against contracted activity targets.

2.3.5 Serious Incidents

Figure 14 Reported Incidents 2019/20

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
SI's	7	3	6	0	4	5	4	4	2	8	5	2
All Incidents	492	592	557	598	580	561	638	627	588	747	639	657
PSI	256	284	287	325	366	354	401	382	371	477	429	549

2.3.6 Patient Safety related incidents

Figure 15 Patient Safety Related incidents Submitted to the NRLS

	Number of Incidents per 1000 bed days	Percentile of 56 other reporters within mental health cluster
1 st October 2017 – 31 st March 2018	59.30	No evidence of potential under reporting
1 st April 2018 – 30 th September 2018	46.65	No evidence of potential under reporting
1 st October 2018 – 31 st March 2019	47.11	No evidence of potential under reporting
1 st April 2019 – 30 th September 2019	69.22	No evidence of potential under reporting

Figure 16 Patient Safety Related incidents

	None	Low	Moderate	Severe	Death	Total
1 st October 2017 – 31 st March 2018	1083	522	22	0	5	1632
	66.4%	32%	1.4%	0%	0.31%	
1 st April 2018 – 30 th September 2018	690	599	29	0	12	1330
	51.9%	45%	2.2%	0%	0.9%	
1 st October 2018 – 31 st March 2019	689	584	29	1	14	1317
	52.7%	43.9%	2.2%	0.1%	1.1%	
1 st April 2019 – 30 th September 2019	1106	711	13	0	11	1841
	60.1%	38.6%	0.7%	0%	0.6%	

2.3.7 Patient environment

According to NHS England, “Good environments matter”. The expectation is that every NHS patient should be cared for with compassion and dignity in a clean and safe environment and that if patients believe that standards fall short then they should be able to hold the service and its management to account.

The annual Patient Led Assessment of the Care Environment (PLACE) was introduced in early 2013 and replaced PEAT (Patient Environment Action Team).

The Trust PLACE 2019 assessments were completed on all hospital sites in October 2019. This information, along with all other PLACE assessment data was subsequently collated together to create the PLACE 2019 Action Plan.

Summary Results

The table below shows the Trust’s scores against national results over the last 2 years. Substantial changes were made to PLACE with over 400 modifications to the question set therefore limited comparisons can be made to previous years.

The Food domain has now been split into 3 sections, previously scored as 1 officially. This separates the food presented to the patients to the menu types and service given as well as regulatory questions.

Five domains have fell below the national average although scores in three of these areas have risen based on the previous year’s scores.

The Trust continues to have an ongoing program of improvement and monitoring to raise environmental standards, which are monitored through the Trust Governance program.

Figure 17 National PLACE Scores vs Trust Results 2019

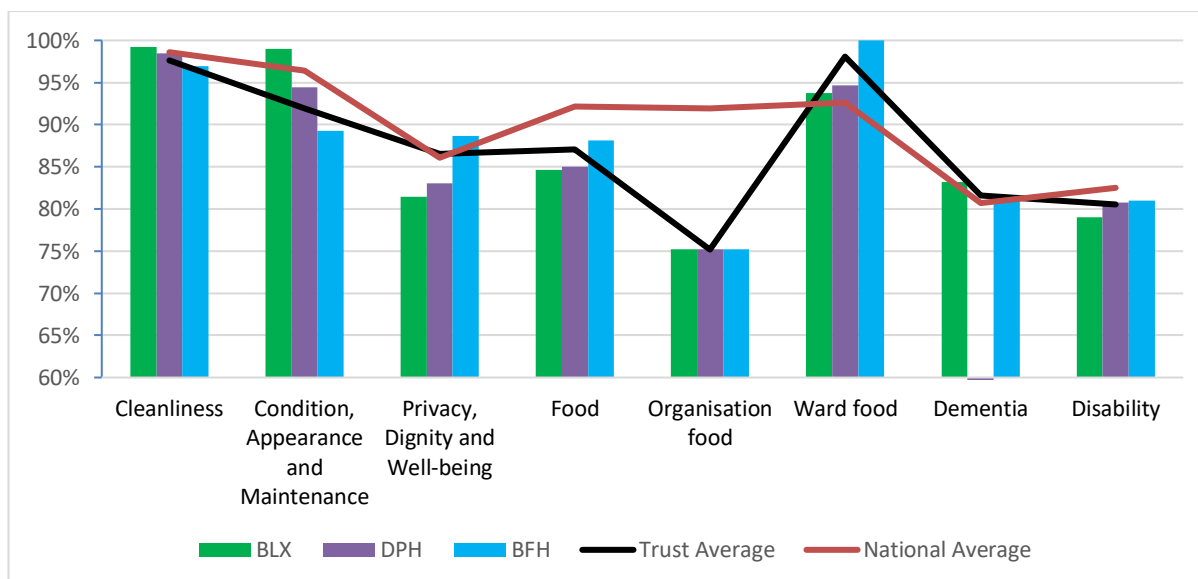
Domains	National Average			Trust Average		
	2017	2018	2019	2017	2018	2019
Cleanliness	98.40%	98.5%	98.60	95.13%	96.16%	97.61
Condition Appearance and Maintenance	94.02%	94.3%	96.44	87.58%	92.67%	91.96
Privacy, Dignity and Wellbeing	83.70%	84.2%	86.09	82.65%	86.81%	86.50
Food	89.70%	90.2%	92.19	85.95%	87%	87.03
Organisation Food	Not recorded	Not recorded	91.92	Not recorded	Not recorded	75.18
Ward Food	Not recorded	Not recorded	92.62	Not recorded	Not recorded	98.08
Dementia	76.70%	78.9%	80.70	78.12%	87%	81.61
Disability	82.50%	84.2%	82.52	74.31%	86.61%	80.56
Comments				Below in five domains	Below in three domains	Below in five domains
2017 Data	Trust Scores			>1% below national average for year <1% below national average for year > National average for year		
2018 Data						
2019 Data						

Figure 18 National PLACE Scores 2019 vs Trust Average (by site)

Six domains:-	Cleanliness	Condition, Appearance and Maintenance	Privacy, Dignity and Well-being	Food	Organisation food	Ward food	Dementia	Disability
National Average	98.60	96.44	86.09	92.19	91.92	92.62	80.70	82.52
Trust Average	97.61	91.96	86.50	87.03	75.18	98.08	81.61	80.56
BLX	99.19↑	99.03↑	81.43↓	84.66↓	75.18	93.75	83.16↓	79.05↓
DPH	98.47↑	94.47↑	83.02↓	85.04↑	75.18	94.68	-	80.77↓
BFH	96.98↓	89.30↓	88.67↑	88.11↑	75.18	100	81.14↓	80.98↓

Green = Improved since 2018 Red = Decline since 2018

Figure 19 National PLACE scores 2019 vs Trust Average (by site) in graph format



Following publication of the yearly PLACE results, the Trust has put in place an action plan to address the areas identified for improvement. These include, remedial actions taken on cleanliness, new food supplier sourced with implemented, a food and hydration working group to be implemented and PLACE standards considered during building refurbishments. Actions taken to improve the Trust’s PLACE score will be monitored through the Infection Prevention and Control Committee and the Estates and Capital Planning Group. New site operational groups to be implemented to assist all in ensuring any environmental issues are dealt with swiftly with input from all elements of the Estates and Facilities team along with clinical teams

Duty of Candour

Duty of Candour procedures have contributed to the further development of a patient centered model of care. There has been a robust procedure developed for identifying incidents that fall within the set criteria and follow up has been consistent.

Incident data has been reviewed and followed up to give assurance that the process for Duty of Candour has been followed and evidenced. Systems have been developed to capture and evidence compliance with the Duty of Candour regulations.

Furthermore where incidents have taken place that do not necessarily meet the criteria of the Duty of Candour regulations, there is evidence to support a positive open culture exists; evidenced through clear documentation within electronic incident forms and in care records.

There have been 38 cases during 2019/20 where the process for Duty of Candour has been applied. All cases were investigated as serious incidents.

Figure 20 Number of Trust Incidents where the Duty of Candour process has been enacted.

	2019									2020		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Duty of Candour applied	3	6	3	0	2	4	1	7	2	5	2	3

Internal Audit Findings

The Trust has a Being Open/Duty of Candour Policy and an Incident and Serious Incident Investigation Policy which provide guidance on identifying and dealing with Duty of Candour incidents in compliance with CQC and statutory guidance.

Our testing found that incidents were appropriately classified and where required were properly investigated.

The Trust needs to improve its arrangements for keeping written records of face to face meetings with patients or their representatives as not all meetings were properly recorded in accordance with CQC guidance and to be able to demonstrate compliance with the Care Act.

2.3.8 National Clinical Audits and Confidential Enquiries

During April 2019 to March 2020, three National Clinical Audits and one National Confidential Enquiry covered NHS services provided by Dudley and Walsall Mental Health Partnership Trust. These were:

- Prescribing Observatory for Mental Health (POMH): Prescribing for depression in adult mental health
- Prescribing Observatory for Mental Health (POMH): Use of depot/LA antipsychotic injections for relapse prevention
- National Clinical Audit Psychosis (NCAP) : Re-audit Early Intervention in Psychosis services
- National Confidential Enquiry into Suicide and Homicide

During that period the Trust participated in 100% of the National Clinical Audits in which it was eligible to participate in and a summary is provided below:

Figure 21 National Clinical Audits

Audit Title	Participation	% Cases Submitted
POMH: Prescribing for depression in adult mental health	Yes	No set sample size 50 submitted
POMH: Use of depot/LA antipsychotic injections for relapse prevention	Yes	No set sample size 48 submitted
NCAP: Re-audit Early Intervention in Psychosis services	Yes	286 cases submitted 100% of requested sample group
National Confidential Enquiry into Suicide and Homicide	Yes	Criteria Met

2.3.13 Local Clinical Audits

The Trusts own Quality Priority Audits for 2019/20 were derived from a number of key sources including trend analysis of incidents, complaints, commissioner requests, national best practice guidelines (e.g. NICE) and to gain assurance with regards to newly embedded processes and to ensure embedded quality processes were safe and effective. A selection of audits commissioned to support these processes and the key findings or recommendation arising from these audits is detailed in the table below:

Figure 22 Trust Priority Local Clinical Audits

Title of Audit	Summary of Actions / Recommendations
Domestic Violence	<p>The purpose of this audit was to provide assurance that staff understand their roles and responsibilities when working with clients who present to Dudley and Walsall Mental Health Trust and disclose domestic abuse.</p> <p>Findings were positive, with over 90% of staff that raise alerts around domestic abuse having completed domestic abuse training provided by the Trust. Overall staff are confident in taking action where risks are identified, producing reports and referrals when necessary. Staff were aware of the Domestic Abuse Policy, where to access it and how to use the Safe Lives DASH screening tool.</p> <p>The following recommendations are being implemented in response to this audit:</p> <ul style="list-style-type: none"> • A review of the Domestic Abuse Policy to reflect updated legislation • Update and cascade of the Domestic Abuse bulletin • Development and cascade of a briefing on Domestic Homicide Reviews
Care Act Compliance	<p>The aim of the audit was to improve the Trust's compliance with the legislative framework set out in the Care Act 2014 and against the internal policy and pathways in place.</p> <p>In 78% of audit cases where an abuse was identified the adults, consent to the alert had been sought and recorded and in 67% of cases their desired outcome was recorded. 80% of cases had a formal outcome recorded on the database at the time of audit. In 90% of cases the referrer was advised of the outcome.</p> <p>The following recommendations are being implemented in response to this audit:</p> <ul style="list-style-type: none"> • A 7 minute briefing around the Safeguarding Adult Review criteria and process, will be created to raise awareness of the existing process amongst all staff • The Walsall Practice Review Flowchart and Safeguarding Adult Review referral form will be linked onto the safeguarding webpage • Positive Behavioural Support will continue to be utilised alongside individualised care planning, including service users formulating their own safety plan • The role out of the new Electronic Patient Record system following the merger with Black Country Partnership Foundation Trust will lead to the pathway for sharing information between the Trust with ASC can commence and be monitored by both agencies
Falls	<p>This audit forms part of the Patient Safety First Quality Improvement Priority, and is completed on a bi-annual basis.</p> <p>There has been an overall improvement in a urinalysis being completed on the day of admission. There is good evidence of incident reporting and review of the falls risk assessment which is consistent across all areas. In older adult teams there is good evidence of consistency in documenting 'fear of falling'. An improvement in the review of risk assessment post falls has been recorded.</p> <p>The following recommendations are being implemented in response to this audit:</p> <ul style="list-style-type: none"> • Urinalysis audit question amended to reflect the target of 24 hours • Acute wards falls champions to address inconsistencies around recording 'fear of falling' <p>A decrease in the completion of body maps post fall was recorded. Falls champions and leads will take action to improve this by raising awareness with staff.</p>

<p>Care Programme Approach Re-audit</p>	<p>This audit is undertaken annually to monitor compliance against standards and has been completed for each Community Recovery Service and Community Older Adults Team. Overall improvement was noted in capturing employment status and accommodation status within care records. Recording progress and developments since the last review has increased and consideration of the client's education and training is evidenced in 92% of cases. Improvements have been made in the majority of areas of risk assessment.</p> <p>The following recommendations are being implemented in response to this audit:</p> <ul style="list-style-type: none"> • Performance around care plans, risk assessments and review documentation is available to all team members, and this information is closely monitored by team managers through the BI Hub. CPA Performance will be closely monitored through supervision for both frontline staff and team managers • Training regarding high quality care planning will be arranged to support staff • Operational Quality Lead will work closely with teams to ensure staff are aware of the requirements for and benefits of working in partnership with service users and their carers/ families regarding all aspects of care • Staff will be reminded of the importance of recording risk information at every contact • Quarterly audits are completed within each team which include aspects of the care process, such as risk assessment and care planning. Actions are developed and implemented following these and any support requirements are identified
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2.3.9 Clinical Research

The Trust had a fantastic year in the area of research recruitment with an achievement of over 100%. 374 patients were recruited to various health specialties exceeding its target of 371. The R&I managers and the research clinical lead have worked hard to create more awareness of research within the Trust.

Patients, carers and staff were offered the opportunity to take part in 13 portfolio research studies across the Trust, including observational, interventional studies and commercial trials. Most of these trials generated income for the Trust.

The R&I have successfully completed the clinical trials pharmacy department with the addition of recruiting a pharmacy technician. This will ensure that upcoming commercial clinical trials can be done solely within the Trust and all commercial funds relating to pharmacy will be allocated to the Trust

The Trust has now completed its first phase 2 clinical trial. The study was examining the effectiveness of a new drug on the cognition of patients with schizophrenia. The trust now awaits the result/outcome of the study

The R&I department is currently working with the head of nurse development to provide CPD training for nurses. 2 sessions have already been done and the overall feedback response was excellent.

The appointment of the head of R&I has been vital in ensuring that both DWMH and BCPFT R&I team have a collaborative working system and also working with senior managers to allow rapid implementation of quality improvement and research across both trusts.

2.4 Service Experience

Understanding patient experience is important to the Trust in order to ensure that our services are developed and improved to meet service users' needs through listening to peoples' experiences and views, responding comprehensively to feedback and demonstrating what has been improved as a result. The following are a selection of indicators chosen by the Trust as important measures of patient experience.

2.4.1 Service Experience Dashboard

The Trust manages and monitors the following service user experience indicators at all levels across the Trust. A Service User Experience dashboard example is shown below.

Figure 23 Month 12 Service User Experience Dashboard

Service User Experience – Month 12 (March)				
<i>Indicator</i>	<i>Period</i>	<i>Target</i>	<i>Actual</i>	<i>RAG</i>
Friends and Family Test - % of Promoters	Monthly	70%	66%	A
New Complaints	Monthly	13	13	G
New Concerns	Monthly	23	25	A
% Complaints/Concerns regarding Care/Treatment	Monthly	80%	27%	G
Compliments	Monthly	35	28	A
Response Breaches	Monthly	30%	35%	A

2.4.2 Compliments, complaints and concerns

In addition to our focus on quality, we recognise that sometimes people's experience of our services is not always as positive as we would hope. The Trust's complaints policy is based on the Parliamentary and Health Service Ombudsman's (PHSO) principles for remedy; getting it right; being customer focused; being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement.

The Trust also incorporates the user-led "vision" of the complaints system developed by the PHSO, Local Government Ombudsman and Healthwatch England. This framework was created from the findings of the primary research with patients, service users, frontline staff and stakeholders that lay behind it. There are five main areas to the framework which the Trust aims to follow and achieve which is incorporated into the Service Experience Desk induction programme, complaints training and promoted throughout the Trust.

During the period April 2019 to March 2020, the Trust received a total of 170 formal complaints (46 of which were withdrawn or closed); 332 informal concerns and 425 compliments.

The number of complaints received is relatively small compared to the number of patients we see and treat each year.

72% of responses sent during this financial year met the Trust's target of 45 working days.

Figure 24 Compliments and Complaints data

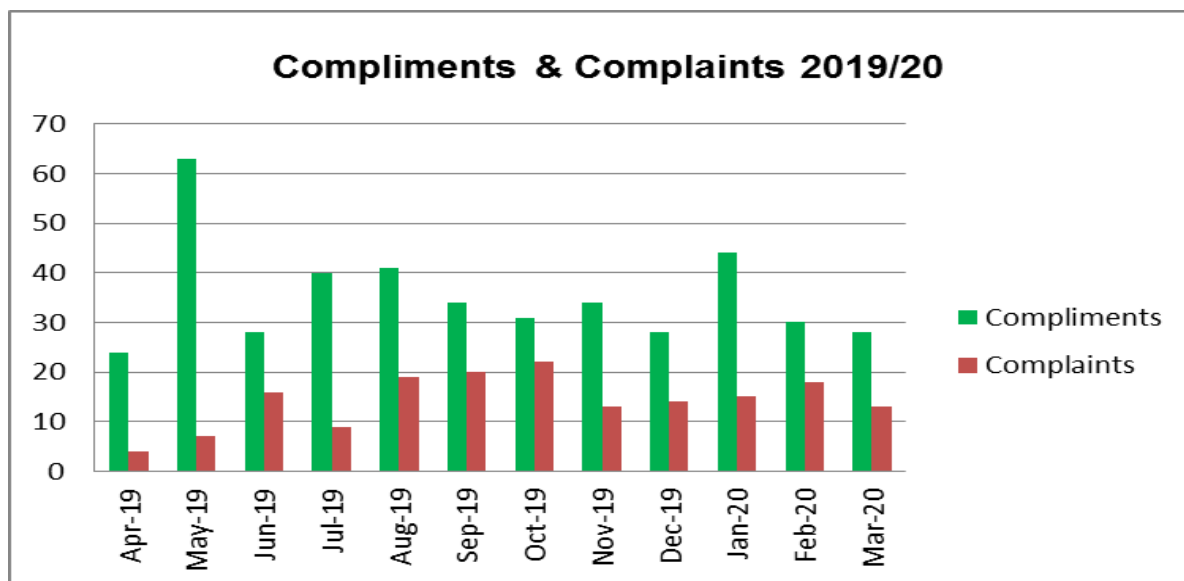
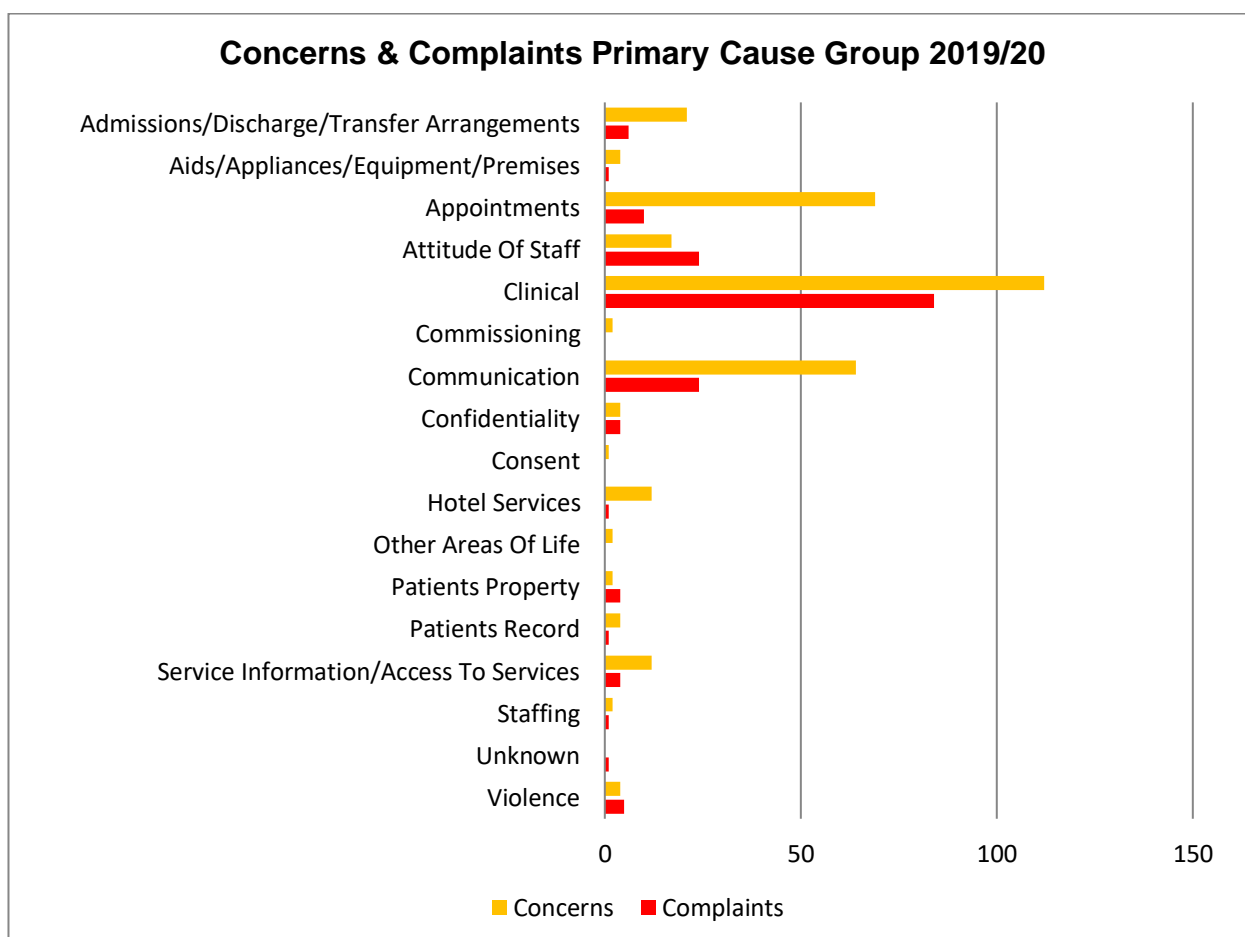


Figure 25 Complaints and Concerns by Cause Group



Compliments

Over the last twelve months, we are pleased to say we have received a large number of compliments (425) from people who have accessed our services, highlighting cases where the quality of our services has been recognised and appreciated.

The Service Experience Desk (SED) feature “On a Happy Note” highlights the positive comments made by service users about their care by posting a selection of experiences from service users on the Trust Intranet every month.

Some examples of what people have said about our services are shown below:

- *My new psychiatrist was so kind and understanding. He listened to me and gave me eye contact when addressing me. He made me feel cared for, and didn't make me feel as though I was wasting his time. He was everything I hoped a psychiatrist should be and I came away feeling much better. He is certainly an asset to your team.*
- *I could not ask for better nurses. I was unwell and visited by my nurse who felt I needed to be in hospital. I felt she did beyond what was expected to make sure I was looked after and safe. I was visited by the nurses in hospital and was supported towards my discharge. I feel this is the best thing that anyone could have happen to someone in my situation and I look forward to their visits – it's helped me tremendously.*
- *Thank you so much for all the help and support you've given me over the past 2 years. I cannot even tell you how much you've helped me and I'm really grateful for all the support, especially at times when I had no one else to turn to. You have saved my life more than once and I cannot thank you enough. You have completely turned my life around and I'm in a much better place now than I could've ever hoped to be in when we first met. I will remember our appointments forever and from the bottom of my heart I wish you all the happiness in the world.*
- *I feel I need to say how well the staff have treated me on all shifts since I was admitted. I have been treated with respect even on my darkest days and during my recovery.*
- *Staff members are kind, caring and take time to talk to you. They are easy going and make you feel welcome and find time to help you. I enjoy the mental health awareness sessions. Staff are considerate to patients and do not judge you and some go the extra mile to meet patient needs.*
- *Thank you for your advice, support, love and help you have given me over the past couple of months. We need more nurses like you in this profession. The information you have provided me with will help sort out my financial issues and being a single parent. You are an amazing beautiful lady who has a heart of gold and I won't ever forget you.*
- *The clinician I saw today has helped me more with my OCD than anyone I have ever seen and I have had OCD for around 15 years. Everything he said made sense and made me feel like there is a future for me, a positive future and that I will be able to get better and enjoy my life. He was very professional and had a lot of knowledge about my illness and about psychology in general. He was also very polite and welcoming. Everything he said today I will remember and use in the future and in my journey to recovery. His advice has been invaluable. A highly recommended clinician.*
- *Thank you for your support and kindness, for giving me the strength to lift the lid on my past, empty my stress cup and love myself again. I am empowered! You are a natural and I'm thankful for meeting you.*
- *Thank you for all your help, advice and support that you have given me during my therapy. You should be proud to do a job that really makes a difference to people's lives. Can't thank her enough. She has given me my life back! Her methods are brilliant and I will never forget the great work she has done with me. Literally a miracle worker. Thank you*

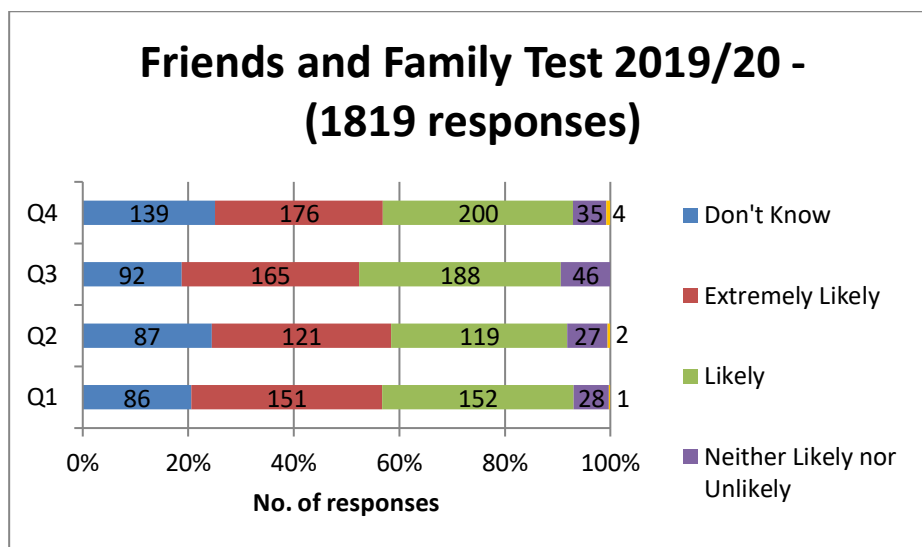
2.4.3 Friends and family test – net promoter

Introduced in April 2012, the Friends and Family Test (FFT) asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. This means patients are able to give feedback on their experience of our services, giving us a better understanding of the needs of our patients and enabling improvements.

The Trust implemented this test in 2013 as part of a CQUIN scheme. People being discharged from community services were asked “How likely is it that you would recommend this service?”

In 2019/20 of the 1819 people asked, 69.9% responded with ‘likely’ or ‘extremely’ likely. The full results are shown below.

Figure 26 Friends and Family Test Data



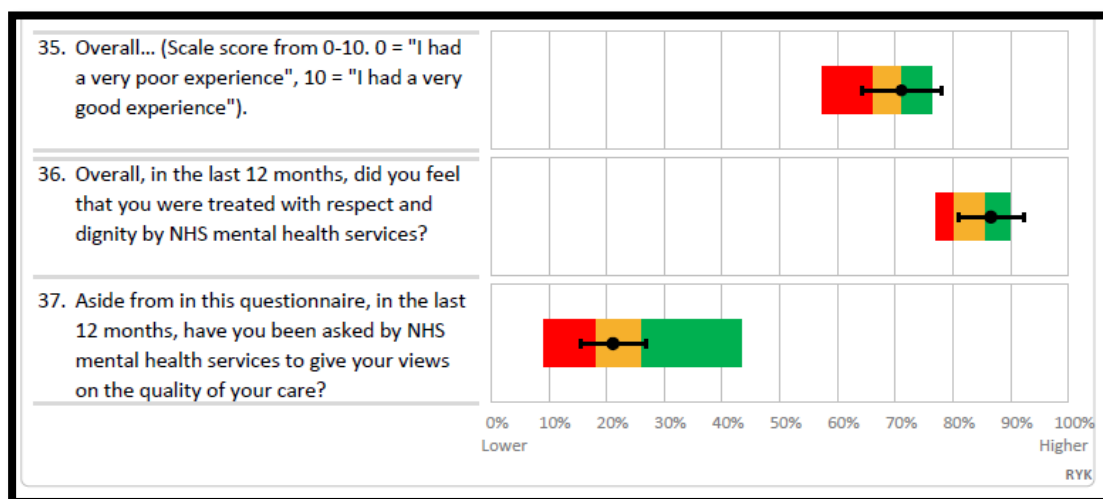
2.4.4 Community Mental Health Survey 2019

The Annual Community Mental Health Survey 2019 was conducted independently for the Trust by Quality Health. This involved a questionnaire being sent out to around 850 people who received community mental health services. The response rate was 28% (234 usable responses received from a basic sample of 831). The key findings are shown below.

Figure 27 Summarising Statement

Trust	Summarising Statement from Quality Health
Dudley and Walsall Mental Health Partnership NHS Trust (RYK)	<i>The overall results for the Trust are generally good. Most scores are in the top 20% and intermediate 60% of Trusts surveyed by Quality Health. Although there are two scores that fall into bottom 20% range.</i>

Figure 28 Survey Overall Experience



The figure above shows that for questions 35 and 36 the Trust remains in the top 20% of all Trusts. Question 37 was a new question introduced in 2019 for the first time. In this first year we can see the Trust performs in the intermediate 60% of all Trusts.

The overall results for the Trust continue to be good with the Trust performing in the top 20% of all Trusts surveyed following on from the success of 2018. The Trust scored in the top 20% in a number of areas including health and social care workers, crisis care, Support and Wellbeing as well as elements within organising/planning care and medicines.

Featured within the Intermediate range included elements from care and treatment, planning, reviewing, medicines, and therapies. Two scores were ranked in the bottom 20% of all Trusts which came from questions relating to organisation of care and Therapies.

Following the capture of this data, action plans were drawn together with the related services to look at how to improve areas where we could have scored higher, beginning with the lowest rated scores.

Figure 29 Benchmarking against other Trusts

	Highest 80% Threshold	Our score	Highest scoring Trust
Patients given enough time to discuss their needs and treatment	76.3%	76.3%	81.8%
The people the patient saw understood how their mental health affected other areas of their life	72.9%	73.7%	76.4%
The person in charge of their care does well at organising the care and services they need	85.4%	87.4%	88.4%
Patient was involved as much as they wanted in agreeing the care they received	74.2%	75.6%	78.8%
Care agreement took personal circumstances into consideration	76.3%	76.6%	78.6%
Decisions were made jointly between patient and staff during care reviews	77.9%	78.7%	83%
Patient aware of who to contact out of hours if having a crisis	73.4%	75.2%	86.1%
Patient got the help they needed when contacting Crisis	71.8%	73.2%	80.4%
Patient was involved in decisions about the medication they received	73.3%	74.1%	77.4%
Patient was provided with advice or support about physical health needs	49.3%	51.3%	56.6%
Support and advice was provided to help patient keep or find work	46.2%	46.3%	53.7%

Patient has been provided with information relating to getting support from others who have the same mental health needs	37.7%	38.8%	45.9%
	Lowest scoring Trust	Our score	Lowest 20% Threshold
Patient has been informed who is in charge of organising their care	58.4%	67%	69.3%
Therapies were explained in a way the patient understood	74.6%	75.9%	78%

Areas for action focus on maintaining the positive's highlighted by the survey and addressing some areas for improvement. In particular those two areas in which the Trust falls within the lowest 20% of all Trusts. There are also a number of intermediate scores which suggest room for improvement.

2.4.5 Learning from feedback

Over the past twelve months, 7 Experts by Experience (EBEs) have been involved in raising awareness of Trust activities and gaining valuable feedback from service users and carers. These views have then been reported to Service Managers and have been used when shaping improvement projects. This feedback alongside informal concerns, and comments made to the Service Experience Desk as well as that gathered from surveys and questionnaires, has helped services make improvements.

Some of these have been actioned swiftly whilst others have required further investigation before being implemented. A selection of actions that have been carried out as a result of feedback from those who use our services, their relatives and carers are shown below:-

Figure 30 You Said – We Did

You Said:	We did:
Where do we go for support with stopping smoking now that I can't smoke?	Smoke free Q&A session organised for inpatients who wish to have advice about stopping smoking. Patients upon entry are asked if they smoke and if so, where they can and cannot smoke and how to go about asking for support with quitting.
If I want to speak to someone to get more information about my medication how can I do this?	Pharmacists attend each inpatient ward on a weekly basis to carry out 1-1 sessions if requested by patients and are available for patients to ask questions if needed. If a patient wishes to speak to a pharmacist outside of these visits they can either speaking to the prescribing nurse or can speak to a pharmacist over the phone.
We want more digital games on the ward to pass the time.	Some patients were familiar with using RITA to play games, use apps and to spark conversations amongst patients. The system which had been previously moved to the staff office was transferred from the office to one of the TV lounges to be used by patients at their leisure.
We need more fresh fruit on the ward. There is also no soya milk or decaffeinated coffee available.	Daily fresh fruit is provided to each of the wards both at BFH and DPH. Soya milk and decaffeinated coffee is available upon request from the kitchen. Patients have decided that if there is any leftover fruit at the end of the day, they will make it into a fruit cocktail.
We need to have more groups and activities both on and off the ward	Additional playing cards, dominoes, puzzles, books, arts and crafts resources, sponge balls, have been provided for patients to use at their leisure. Walking groups, mindfulness sessions, healthy eating groups, movie evening and breakfast clubs have been organised upon patient request and OT's actively speak to patients about the types of activities they would like to see across the ward.

<p>It is difficult to see what activities are on the weekly timetable boards when they are displayed in the communal areas as most of us forget they are there.</p>	<p>Activity timetables on the dementia wards have now been made available in all bedrooms as well as in the communal area so that patients have a more prominent reminder of what activities are taking place that week.</p>
<p>It would be nice to have a more regular cooking group or one off treat nights where we can have traditional meals like takeaways.</p>	<p>2 breakfast groups are facilitated on Wednesdays and Fridays where patients can cook their own breakfast. A cooking group is also available at Birch Hub on a Thursday. Occasional treat meals, that don't feature on the usual menus take place sporadically including a fish and chip supper, bacon rolls on a morning, breakfast club on the weekend mornings.</p>

2.5 Workforce Performance

2.5.1 Workforce Dashboard

The Trust manages and monitors the following workforce indicators at all levels across the Trust. A Workforce Dashboard example is shown giving the trends over the last 12 months.

Figure 31 Month 12 workforce dashboard

445 Dudley and Walsall Mental Health Partnership NHS Trust													Mar-20
Staff in Post													
	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Headcount		1246	1264	1275	1280	1288	1301	1300	1319	1332	1349	1352	1363
Funded Establishment		1221.4	1221.4	1221.4	1310.1	1310.1	1310.1	1310.1	1310.1	1310.1	1310.1	1310.1	1310.1
Staff in Post FTE (Contracted)		1116.7	1129.4	1142.8	1146.7	1156.4	1167.1	1164.6	1186.3	1200.0	1223.6	1224.4	1228.5
WTE Variance		104.7	91.9	78.5	163.5	153.8	143.1	145.6	123.9	110.2	86.5	85.7	81.7
Vacancy %	10.0%	8.57%	7.53%	6.43%	12.48%	11.74%	10.92%	11.11%	9.45%	8.41%	6.60%	6.55%	6.23%
Clinical Vacancy %	10.0%	12.40%	12.42%	12.32%	12.67%	11.80%	11.27%	11.30%	10.01%	9.00%	6.28%	7.06%	6.91%
Turnover % (12 Months)	10-13%	11.91%	11.47%	11.42%	10.81%	10.15%	10.12%	10.29%	10.52%	10.43%	9.95%	10.45%	10.73%
Turnover % (in Month)	0.7-1.2%	0.50%	0.27%	1.03%	0.65%	0.52%	1.07%	1.09%	0.61%	0.58%	0.94%	0.97%	1.40%
Absence													
	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Sickness % (Month)	4.68%	4.44%	3.82%	4.20%	3.94%	4.48%	5.18%	5.99%	5.11%	4.56%	4.84%	4.55%	4.29%
Sickness Days Lost FTE (Month)		1,536	1,328	1,437	1,398	1,602	1,810	2,159	1,809	1,691	1,826	1,618	1,627
No of Sickness Episodes (Month)		195	179	207	175	189	233	298	234	245	247	243	195
Cost of Sickness (Month)		£161K	£128K	£148K	£137K	£144K	£160K	£200K	£159K	£147K	£182K	£138K	£139K
Maternity % (Month)		1.72%	1.88%	1.72%	1.94%	2.33%	2.31%	2.45%	2.57%	2.62%	2.77%	2.55%	2.52%
Sickness % (12 Months)	4.68%	4.37%	4.34%	4.33%	4.31%	4.33%	4.41%	4.52%	4.60%	4.61%	4.64%	4.66%	4.66%
Long Term Sickness % (12 Months)		64.0%	61.0%	63.1%	63.6%	63.2%	64.3%	64.9%	66.1%	65.7%	65.8%	66.3%	65.9%
Cost of Sickness (12 Months)		£1,654K	£1,675K	£1,687K	£1,699K	£1,713K	£1,741K	£1,785K	£1,853K	£1,840K	£1,915K	£1,910K	£1,893K
Development													
	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Appraisals Completed		826	832	805	822	820	889	893	906	899	902	901	887
Appraisals Outstanding		164	188	173	153	160	100	105	106	120	145	159	193
Appraisals Required		990	1020	978	975	980	989	998	1012	1019	1047	1060	1080
Appraisal %	85%	83.43%	81.57%	82.31%	84.31%	83.67%	89.89%	89.48%	89.53%	88.22%	86.15%	85.00%	82.13%
Combined Training %	90%	90.14%	90.42%	90.21%	88.11%	88.48%	90.02%	89.80%	91.00%	91.69%	91.71%	90.81%	88.72%
Number of Training DNAs		79	120	149	75	65	78	130	94	74	108	110	-
Training DNA Rate %		21.70%	24.69%	27.24%	17.86%	18.68%	19.70%	18.47%	12.48%	14.57%	20.57%	22.22%	-
Supervision %		41.08%	37.63%	36.67%	37.07%	39.24%	43.68%	49.65%	51.47%	46.33%	49.11%	51.16%	-

2.5.2 Staff survey

The positive upward trend in previous years has continued and in 2019 Dudley and Walsall Mental Health Partnership NHS Trust 's Staff Survey results saw us as one of the best performing Mental Health / Learning Disability Trust in the country and best performing of all provider trusts in the Black Country.

The Trust values staff feedback and recognises that the annual Staff Survey is the largest and most comprehensive means of understanding what is working well and what opportunities for improvement and development there are.

Quality Health (QH) acts independently on behalf of the Trust to undertake the Staff Survey which is sent to all permanent staff, via an approximately 80:20 split, of online and paper surveys to offer the widest opportunity for completion.

The QH sample size for Dudley and Walsall Mental Health Partnership NHS Trust, NHS national staff survey was 1257, after excluding ineligible staff, the final sample was 1239, of which 788 responded. This gave us an overall response rate of 63.6% compared to 59.1% in 2018, comparing very favourably against a 2019 sector average response rate of 54%, across the 23 specialist Mental Health and Learning Disability trusts.

This ranks the Trust as the 20th highest response rate of any NHS trust in NHS England which is measure of high staff engagement.

The overall staff engagement score for the Trust rose from 7.27 out of a possible score of 10 in 2018 to 7.51 in 2019. Placing the Trust first and well above the MH/LD sector average score of 7 and the 13th best placed Trust in NHS England.

The survey questions are summarised into 11 themes, of which the Trust scored as top performing MH Trust across 9 out of the 11 themes in 2019 which are shown in bold below.

Figure 32 Staff survey summary

	DWMH	Best in Sector
1. Equality, Diversity & Inclusion	9.3	(9.3)
2. Health & Wellbeing	6.6	(6.6)
3. Immediate Managers	7.7	(7.7)
4. Morale	6.7	(6.7)
5. Quality of Appraisals	6.5	(6.5)
6. Quality of Care	7.8	(7.8)
7. Safe Environment – Bullying & Harassment	8.3	(8.3)
8. Safe Environment – Violence	9.2	(9.5)
9. Safety Culture	7.2	(7.2)
10. Staff Engagement	7.5	(7.5)
11. Team Working	7.2	(7.3)

For Theme 3, Immediate Mangers the result is the best place of all NHS England Trusts.

The Trust was the best performing in sector against the Themes for Staff Engagement, Morale, Appraisals, Health & Wellbeing, Quality of Care, Safe Environment - Bullying & Harassment

Themes on Engagement & Quality of Appraisal are significantly higher than the sector average for 2019; no themes are scored significantly lower against the sector or against 2018 Trusts results.

Across individual questions 57% are significantly higher than the sector scores and only 2% significantly lower:

- 10c 'On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?' 61% (vs 56% lower score is better)
- 11g 'Have you put yourself under pressure to come to work?' 95% (vs 93% lower score is better)

Trust wide there are no themes that stand out as concerns across the whole organisation however the Trust will continue to strive for improvement and maintain the overall high performance across all areas as we merge.

It will continue to focus on Trust wide initiatives to maintain and improve the survey results, working in partnership with other organisations and NHSI, especially around issues such as staff Health & Wellbeing and Safe Environment - Violence. It sees the main opportunity to improve on the already positive results as being through empowering service lines and departments to use their own specific breakdown reports to focus on their own local priorities.

Themes with scores are available for individual directorates and these have been shared with relevant managers to allow them to select and own their own areas for improvement.

2.5.3 Staff Friends and Family Test

The Trust launched the Staff Friends and Family Test via its intranet, in May 2014 and monitors these results quarterly throughout the year, drilling down into the free text comments as to why people answered the way they did.

Results, including free text comments, are shared with staff and the CEO provides filmed responses to the main questions raised as part of our Engagement strategy to foster an open dialogue between Staff and Board.

This has seen staff stating they would recommend the Trust as a place for treatment/care to friends and family increased from 75% in Quarter 1 2015 to 80% in Quarter 4, February 2020.

Staff stating they would recommend the Trust as a place to work to friends and family increased from 59% in Quarter 1 2015 to 80% in Quarter 4, February 2020.

Figure 33 How likely are you to recommend the Trust to friends and family as a place for treatment/care?

Survey Period	Result
2017/18 Q1	79%
Q2	82%
Q3	National Staff Survey replaces SFFT
Q4	82%
2018/19 Q1	81%
Q2	75%
Q3	National Staff Survey replaces SFFT
Q4	79%
2019/20 Q1	82%
Q2	81%
Q3	National Staff Survey replaces SFFT
Q4	80%

The Trust's performance against this question was as follows:

Figure 34 How likely are you to recommend the Trust to friends and family as a place of work?

Survey Period	Result
2017/18 Q1	71%
Q2	65%
Q3	National Staff Survey replaces SFFT
Q4	66%
2018/19 Q1	71%
Q2	65%
Q3	National Staff Survey replaces SFFT
Q4	77%
2019/20 Q1	76%
Q2	80%
Q3	National Staff Survey replaces SFFT
Q4	80%

2.5.4 Freedom to speak up guardian

The Trust's Freedom To Speak Up Guardian has been in post since November 2016 and works closely with teams at all levels and leaders across the Trust to raise the profile of the service and importance of cultural change where "Speaking Up" is seen as business as usual.

In addition, the Guardian attends Trust Induction and meets Junior Doctors on placement, Students nurses, supports the nurse revalidation programme and attends team and service line meetings.

There has been extensive publicity through Trust Communication channels, the intranet and through posters, leaflets and other means to publicize the role

These all also advertise a dedicated email via which staff can directly and confidentially contact the Guardian, alongside phone call, normal email and face to face.

Staff are also encouraged to raise concerns by any other route they see fit, via professional bodies, unions, management, HR, Safe Guarding and incident reporting – such reports, which can now also be done anonymously, are flagged directly to the guardian.

The role is frequently highlighted and promoted by the CEO through their online and face to face communications. The Guardian not only formally reports directly to the CEO but also has access at any time it is required, alongside access to a nominated Non-Executive Director and Chair; Quarterly reports are provided to the Board on the numbers of incidents, themes raised, these are also fed to the triangulating of reporting of incidents to identify themes or hotspots.

The Guardian's responsibility is to remain in contact with those whose concerns they have escalated on their behalf and to feedback outcomes where this has been done in confidence. Where concerns are progressed with the involvement of the member of staff, be that informally with management, or formally via for example HR, then feedback may come through those channels directly, although the Guardian will ensure both that this has happened and that the member of staff feels their concern has been properly addressed. By maintaining this contact it is also possible to reassure staff that they have recourse to support should they suffer any actual or perceived detriment in cases where they have not asked to remain anonymous.

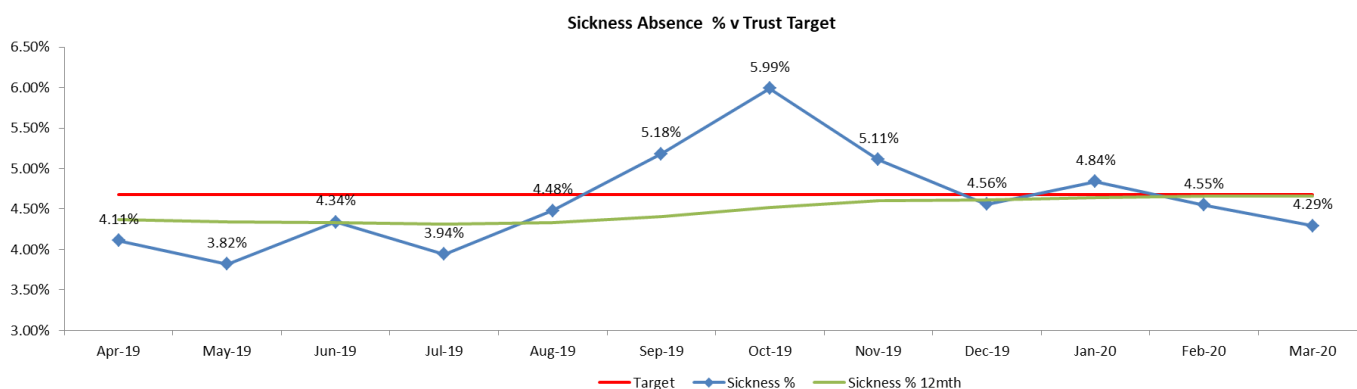
Its approach to Freedom To Speak Up also saw the Trust shortlisted as a finalist in this category at the 2019 Health Service Journal Awards, for its innovative approach in using an animation to tell the real life, anonymised, story of staff Speaking Up and sharing their experiences.

The most recent CQC Inspection positively highlighted the extent of the awareness amongst staff of the Freedom to Speak Up role as a concept, option for raising concerns and of the Guardian as an individual

2.5.5 Managing sickness absence

The Trusts sickness KPI rate is 4.68%, during 2019/20 the Trust's sickness rate was largely under the KPI from an in month perspective and a rolling 12 month perspective. See Figure 33.

Figure 35 Sickness absence % v Trust target



Short and long term sickness

- 79% of sickness episodes lasted 7 days or less, whereas 10% of sickness episodes were 28 days or longer
- Rolling sickness absence remained under the Trusts target of 4.68% for the entire year
- Long term sickness accounts for 66% of sickness for the rolling 12 month period to Mar-20.

Figure 36 Short and long term sickness

Month	Target	Sickness %	Sickness % 12mth
Apr-19	4.68%	4.11%	4.37%
May-19	4.68%	3.82%	4.34%
Jun-19	4.68%	4.34%	4.33%
Jul-19	4.68%	3.94%	4.31%
Aug-19	4.68%	4.48%	4.33%
Sep-19	4.68%	5.18%	4.41%
Oct-19	4.68%	5.99%	4.52%
Nov-19	4.68%	5.11%	4.60%
Dec-19	4.68%	4.56%	4.61%
Jan-20	4.68%	4.84%	4.64%
Feb-20	4.68%	4.55%	4.66%
Mar-20	4.68%	4.29%	4.66%

The HR function works alongside managers and Occupational Health to monitor and manage sickness absence in line with Trust Policy and the Equality Act 2010. A weekly report is managed within HR of all long-term sickness absence cases to ensure early intervention. HR Advisors have been assigned to dedicated service lines to help support the management of sickness absence. Deep dives have been carried out in areas experiencing high sickness levels with action plans put in place to address these and to support managers and staff.

The Trust's occupational health service is supplied under contract with People Asset Management Limited.

Mandatory and Essential Training

During the first quarter Mandatory Training was slightly below the target of 90%. As such, with the Director of People as executive sponsor, the Head of Services, supported by the Learning & Development Manager created Rapid Action Plans to address areas within their service that were below compliance target.

The second half of the year saw a stronger performance with the target consistently exceeded. Covid 19 did have an impact in March with the cancellation of all face-to-face mandatory training. This is reflected in the dip at the end of the year to be slight below 90%.

Those modules that can be completed by e-learning have retained a high level of compliance .

There will be two areas of focus for 2020-21:

- A recovery plan to address mandatory training following the easing of the lockdown
- Combining the Mandatory Training frameworks that existed within Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust to form a unified programme for Black Country Healthcare NHS Foundation Trust

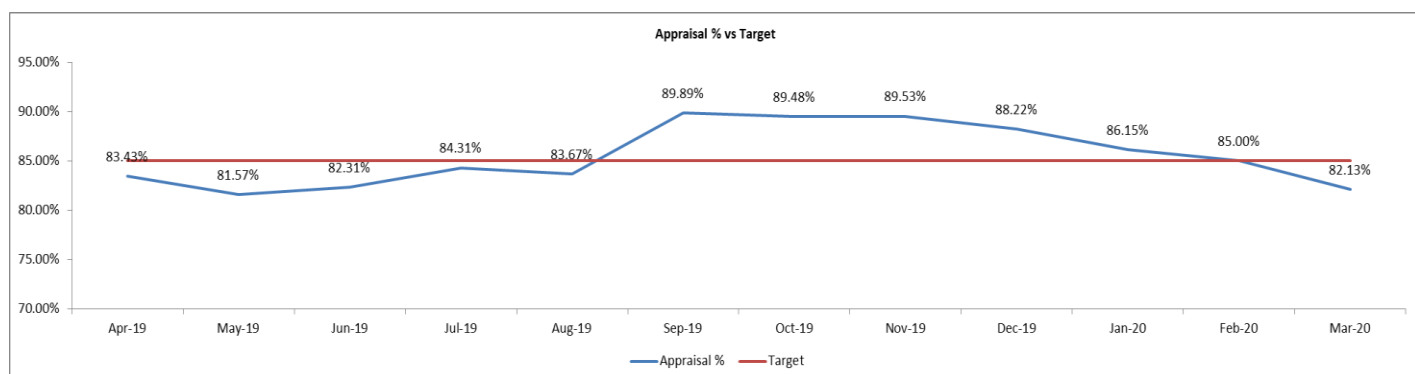
2.5.6 Managing staff performance (Appraisals)

During 2019/20 the level of appraisal activity has been sustained at a good level within the Trust with targets consistently exceeded during the year after a slow start. With the onset of the Corona Virus face to face meetings were cancelled which led to the postponement of staff appraisals with the compliance rate dipping at the end of the year.

The quality of appraisals has been rated highly through staff survey feedback, with staff reporting leaving their appraisal feeling valued by the organization.

Future appraisals (spring 2021) will be conducted in a defined window of February to May in line with our merger partner Black Country Partnership NHS Foundation Trust.

Figure 37 Appraisals



3 FINANCIAL PERFORMANCE

3.1 Financial Trends

The Trust has continued to build financial strength since its formation in 2008, growing its surplus, developing its contracting capabilities and relationships with commissioners, transforming services and continuing to improve the estate from which services are provided.

The following table summarises high-level financial information since the Trust was formed.

Figure 38 High-Level Financial Information

	<i>Income</i> £000	<i>Surplus</i> * £000	<i>Cash</i> £000	<i>Savings</i> £000
2008/09	24,186	202	5,398	1,500
2009/10	66,578	377	6,132	2,000
2010/11	67,918	883	6,230	1,991
2011/12	67,298	1,163	6,932	2,736
2012/13	71,302	3,575	11,923	2,804
2013/14	65,388	1,936	12,748	2,888
2014/15	64,750	888	14,187	2,616
2015/16	64,546	1,960	14,294	2,380
2016/17	66,293	2,199	16,966	2,500
2017/18	69,482	3,384	17,982	3,462
2018/19	74,340	3,050	18,818	2,096
2019/20	81,986	1,629	14,574	2,133

* Breakeven duty in-year financial performance

The table above reflects the following factors:

- 2019/20 was financially another successful year for the Trust – the Trust has delivered a surplus in every year since its establishment in 2008
- An increase in income of almost £7.6m over 2018/19 which reflects Inflation of £1.7m, Mental Health Investment Standard Growth £2.8m, Investments in Liaison and Diversion and Crisis Services £1.4m and Central funding for NHS Pension Scheme Contributions £2.5m, offset against falling levels of PSF and Central Pay Award funding in the year £0.8m
- In line with all other NHS provider organisations the Trust has been required to deliver cost improvement savings (CIP) over recent years. The Trust has delivered over £2.1m of such savings in 2019/20

3.2 Financial Targets

The table below summarizes the Trust's performance against the key financial duties for the year ended 31 March 2020.

Figure 39 Performance against Key Financial Duties

<i>Duty</i>	<i>Target</i>	<i>Performance</i>	<i>Comment</i>
<i>Ensuring expenditure does not exceed income</i>	<i>Breakeven</i>	<i>£1,629,000 Surplus</i>	<i>Achieved</i>
<i>To remain within approved Capital Resource Limit (CRL)</i>	<i>£6,489,000</i>	<i>£6,127,000</i>	<i>Achieved</i>
<i>Achieve a capital cost absorption rate of 3.5%</i>	<i>3.5% (+/- 0.5%)</i>	<i>3.5%</i>	<i>Achieved</i>
<i>To not exceed the approved External Finance Limit (EFL)</i>	<i>£1,421,000 Cash Outflow</i>	<i>£2,119,000 Undershoot</i>	<i>Achieved</i>

3.3 Where does the Trust's Income come from?

The Trust had contracts with 2 key NHS commissioners in 2019/20. These were Dudley CCG and Walsall CCG.

The Trust also provides services to people who live in the boroughs of Dudley or Walsall but are registered with GPs in neighbouring boroughs. These services are covered by contracts with other local CCGs, namely:

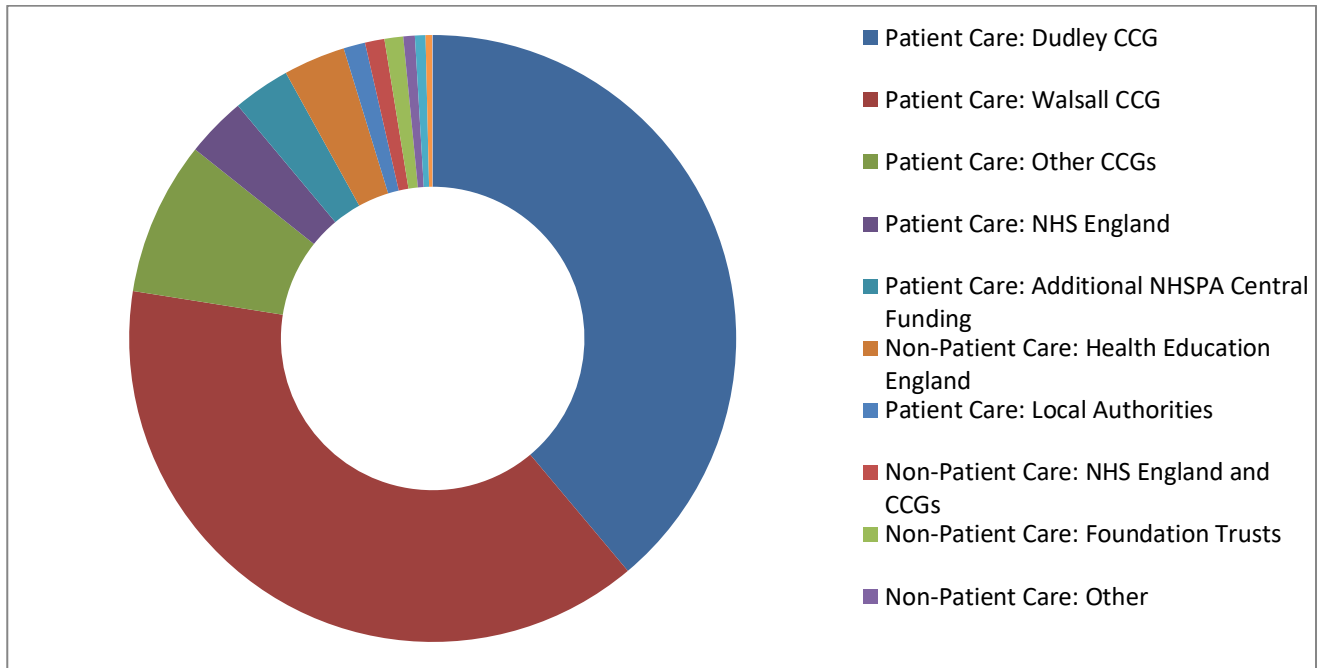
- Sandwell & West Birmingham CCG
- Wolverhampton CCG
- Birmingham & Solihull CCG
- South East Staffordshire and Seisdon CCG
- Stafford and Surrounds CCG
- Cannock Chase CCG
- Redditch & Bromsgrove CCG
- Wyre Forest CCG
- South Worcester CCG

In addition, the Trust provided mental health services to Deaf Children and Adolescents under a contract with NHS England (West Midlands Commissioning Hub) and provided Inpatient Detox Services, CAMHS Tier 2 Services and Step Down Beds under contracts with Dudley Metropolitan Borough Council.

All key contracts for the year were signed.

The Trust received £82.0m of income in 2019/20; a breakdown of where this income was received from is shown in the chart below.

Figure 40 The Trust's Income

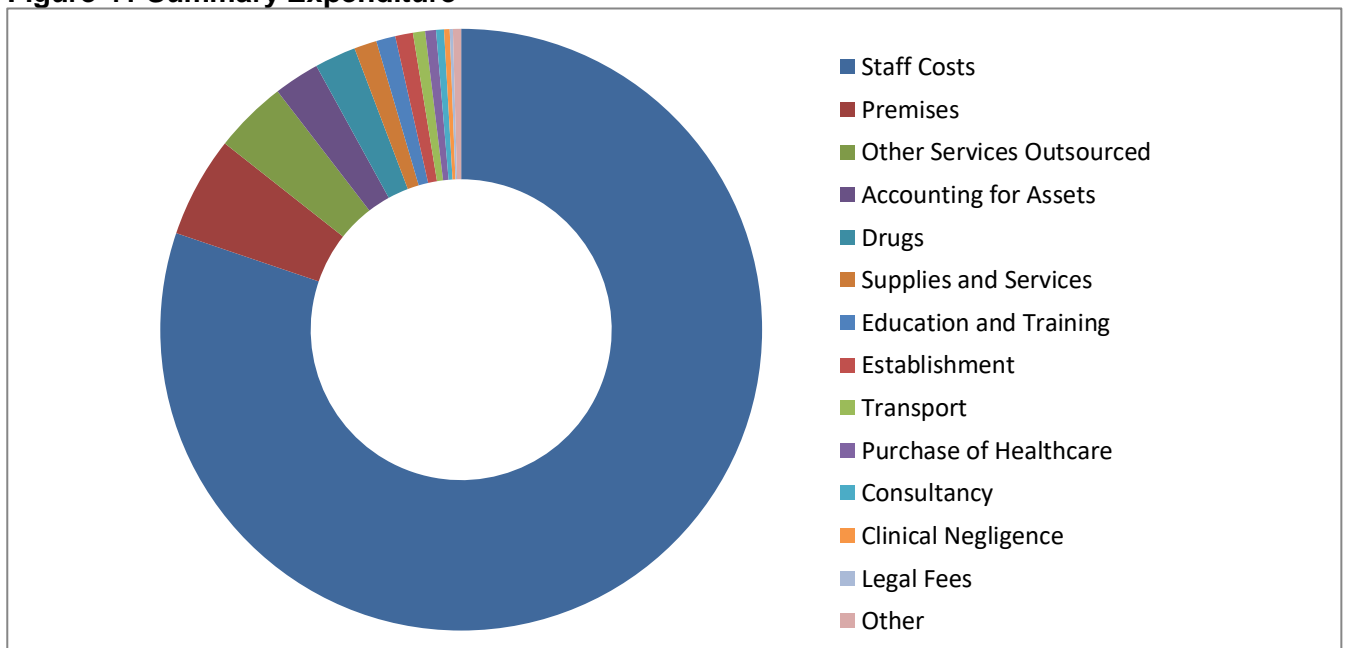


3.4 How is the Trust's money spent?

The Trust's total operating expenditure for the 2019/20 financial year was £79.7m, against £72.7m in 2018/19.

The main driver for the increase is Staff costs incurred in delivering the additional activity and resulting income in the financial year. This is by far the largest element of expenditure incurred by the Trust and relates to salaries and wages of directly employed staff and invoices paid in respect temporary workers employed via employment agencies. On average the Trust employed 1,493 whole time equivalent staff which resulted in employee benefits being paid to staff of £66.0m, this equates to 83% of total operating expenditure.

Figure 41 Summary Expenditure



3.5 Capital Expenditure

The Trust has continued to build on the large sums invested in previous years to improve its estate and IT infrastructure during the financial year, with £6.127m being spent on capital works and investment in infrastructure in 2019/20.

Capital projects undertaken in the year are as follows:

Figure 42 Capital Works Undertaken

<i>Capital Scheme</i>	<i>Expenditure £000</i>
<i>Dorothy Pattison Hospital - Capital Works and Refurbishments</i>	1,710
<i>Bushey Fields Hospital – Capital Works and Refurbishments</i>	255
<i>Bloxwich Hospital – Capital Works and Refurbishments</i>	73
<i>Community Sites - Capital Works and Refurbishments</i>	182
<i>Other Estates Schemes</i>	210
<i>Purchase and Development of IT Software inc. Electronic Patient Record</i>	2,793
<i>Purchase of IT Hardware</i>	196
<i>Purchase of IT Software</i>	99
<i>Purchase of Goscote House</i>	581
<i>Trust Wide – Replacement Ward and Medical Equipment</i>	28
Total Capital Expenditure	6,127

3.6 Payment of Suppliers

3.6.1 Better Payment Practice Code

The Better Payment Practice Code (BPPC) requires organisations to aim to pay all valid invoices by their stated due date or within 30 days of receipt, whichever is later. Performance against this target, over the financial year, was as follows:

Figure 43 Better Payment Practice Code Performance

	2019/20	
	Number No.	Value £000
Non-NHS Payables		
<i>Total Non-NHS trade invoices paid in the year</i>	15,834	33,956
<i>Total Non-NHS trade invoices paid within target</i>	14,370	32,069
<i>Percentage of non-NHS trade invoices paid within target</i>	91%	94%
NHS Payables		
<i>Total NHS trade invoices paid in the year</i>	838	8,101
<i>Total NHS trade invoices paid within target</i>	743	7,079
<i>Percentage of NHS trade invoices paid within target</i>	89%	87%

3.6.2 Prompt Payments Code

The Prompt Payment Code (PPC) sets standards for payment practices and best practice. The code is administered by the Chartered Institute of Credit Management. Dudley and Walsall Mental Health Partnership NHS Trust signed up to the code in October 2009.

3.7 External Audit Services

The Trust's external auditors are Grant Thornton UK LLP, The Colmore Building, 20 Colmore Circus, Birmingham, West Midlands, B4 6AT.

Expenditure recognized with Grant Thornton UK LLP for the period for were as follows:

Figure 44 Auditors Remuneration

	2019/20	2018/19
	£000	£000
<i>Audit services</i>	£59,000	£50,000
<i>Other auditor's remuneration – audit-related assurance services</i>	£12,000	£12,000

3.8 Countering Fraud, Bribery and Corruption

The Trust is committed to ensuring NHS resources are appropriately protected from fraud, bribery and corruption and follows the national counter fraud strategy and the series of standards for providers of NHS services. As an NHS Provider the Trust ensures that NHS funds and resources are safeguarded against those minded to commit fraud, bribery or corruption. Failure to do so impacts on a provider's ability to deliver services and treatment, as NHS funds and resources are wrongfully diverted from patient care.

In order to reduce economic crime against the NHS, it is necessary to take a multi-faceted approach that is both proactive and reactive. The Trust's Local Counter Fraud Specialist (LCFS) follows the four key principles, in accordance with the NHS counter fraud strategy. These are designed to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit crime.

The four key principles are:

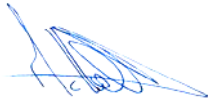
1. **Strategic Governance** - this standard sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation
2. **Inform and involve** those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face counter fraud presentations, public awareness campaigns and media management. The LCFS presents as part of the Trust induction. Working relationships with stakeholders are strengthened and maintained through active engagement
3. **Prevent and deter** economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during counter fraud presentations and using other media opportunities so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards and guidance
4. **Hold to account** those who have committed economic crime against the NHS. The Trust's LCFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the Trust, the LCFS must ensure that investigations are undertaken to satisfy national legislation. The Trust encourages the prosecution of offenders, and where appropriate refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate, and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally wherever possible. Nevertheless, the LCFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution

The Trust has a Counter Fraud Bribery and Corruption Policy in place, which is designed to make all staff aware of their responsibilities, should they suspect offences being committed. When economic crime is suspected, it is fully investigated in line with legislation, with appropriate action taken, which can result in criminal, disciplinary and civil sanctions being applied. In addition, the Trust has the following policies and procedures which support counter fraud work:

- Security Management Policy
- Standards of Business Conduct Policy
- Whistle Blowing Policy and Procedure
- Disciplinary Policy.

If you are concerned about fraud in the NHS, report it to the confidential NHS Fraud and Corruption Reporting Line on **0800 028 4060** or online at <https://cfa.nhs.uk/reportfraud>

I confirm adherence to the reporting framework in preparation of the Performance Report



Signed

Chief Executive, Mark Axcell (31 March 2020)

Date 24 June 2020



Signed

Chief Executive, Paul Assinder (1 April 2020)

Date 24 June 2020


PART B ACCOUNTABILITY REPORT



4 CORPORATE GOVERNANCE REPORT



4.1 The Director's Report



The following table provides detail of the Trusts substantive Directors, Non-Executive Directors, Chair and Chief Executive.



Figure 45 Board Directors 2019/20



Board Member	Profile	Committee Involvement	Declared Interests
 <p>Jeremy Vanes (Chair) Appointed 1 October 2019</p>	<p>Jeremy was appointed as joint chair of both organisations on 1 October 2019 and took over as chair of Black Country Healthcare on 1 April 2020.</p> <p>Jeremy brings a wealth of knowledge and experience to the Trust having spent his 29 year career within health services, public services and the voluntary sector. He was previously chair of the Royal Wolverhampton NHS Trust and stepped down at the end of March 2019 having served as chair for 5 years, and a NED for 8 years – a total of 13 years, which is the maximum time allowed by statute.</p> <p>Jeremy is a chartered manager with diplomas in health and social care and public service leadership. He has been chief executive at four voluntary sector organisations (in Dudley, Sandwell, Warwickshire and Wolverhampton) since 1992.</p>	<p>Jeremy is Chair of the Nominations and Remuneration Committee</p>	<p>Chair in Common of DWMHP and BCP</p> <p>Connection with Citizens Advice, South Warwickshire</p>



Board Member	Profile	Committee Involvement	Declared Interests
 <p>Chris Fearn Non-Executive Director</p>	<p>Christine has over thirty years' experience in the NHS. She began her career as a nurse in 1983. A former Deputy Chief Executive and an experienced NHS Director, she has held a number of senior roles in Acute and Community Trusts and in NHS Commissioning, leading on strategy and transformation. In recent years she has led transformational work across economies and whole systems to deliver new models of care and specifically enable the sustainability of high quality clinical services for patients. She is married with two grown up sons. She loves walking and exploring new places and people.</p>	<p>Chair of Workforce Committee from 1 December 2019</p> <p>Chair of the Quality and Safety Committee to 30 December 2019</p> <p>Member of the Nominations and Remuneration Committee</p>	<p>Director, In-Health Strategic Solutions Ltd</p> <p>Non-Executive Director, University Hospitals of Derby and Burton NHS Foundation Trust.</p>
 <p>John Lancaster Non-Executive Director</p>	<p>John, following a period in the motor industry joined Dairy Crest, initially in finance, before moving into general management where he was responsible for operations in the East of England before working his way up to Operations Director for the National liquid business. In 1996, he joined British waterways as general manager in the Midlands. He retired a decade later, in October 2006 as Managing Director.</p> <p>He served as a Non-Executive Director with West Midlands Ambulance Service for ten years from their formation as a Trust, to obtaining Foundation Trust status. He chaired Stratford town Trust, and South Warwickshire Young Enterprise.</p> <p>John and his wife, Mo, have a home in Stratford-upon-Avon, where they have lived for nearly thirty years. They have three grown up children and John now occupies his spare time rowing on the Avon and running, having completed the New York Marathon.</p> <p>John is a Chartered Accountant</p>	<p>Chair of the Audit Committee</p> <p>Member of the Finance and Performance Committee</p> <p>Member of the Nominations and Remuneration Committee</p>	<p>No declared interests</p>


Board Member	Profile	Committee Involvement	Declared Interests
 <p>Debbie Nixon, Non-Executive Director</p>	<p>Debbie has worked in the NHS since 1981, qualifying as a Registered Nurse in 1985. Debbie has operated as an Executive at Board level for the past 15 years working in both commissioning and provider organisations and has spent the whole of her career in the North West.</p> <p>Debbie's previous role to this appointment was a Chief Operating Officer and Executive Nurse for a Clinical Commissioning Group, also working as the Senior Responsible Officer for Mental Health and Learning Disability programme, across the Lancashire and South Cumbria Integrated Care Partnership.</p> <p>Debbie has also had experience working in a number of national roles that included the National Institute of Mental Health for England as senior consultant and as a review team member for the Department of Health Gateway Team. Debbie is married with two children and is a keen walker and cyclist.</p>	<p>Chair of the Mental Health Act Scrutiny Committee</p> <p>Chair of the Quality and Safety Committee from 1 January 2020</p> <p>Member of the Audit Committee</p> <p>Member of the Nominations and Remuneration Committee</p>	<p>Ownership/Part-ownership Nixon & Evans Consultancy</p>
 <p>Tracey Orr Non-Executive Director to 30 November 2019</p>	<p>Tracey is Support Services Executive for Central England Co-operative, a regional retail Co-operative based in the Midlands and East of England. With a HR background, her responsibilities also include Organisation Design and Change as well as the oversight of a Shared Service Centre.</p> <p>Tracey has worked for over thirty years in the Co-operative movement and is also Chair of the Co-operative Employers Association, a national body for collective bargaining. With a keen interest in mental health matters, she is also a member of the Trust board for Selly Oak School, a specialist school in south Birmingham providing education to support pupils with learning disabilities.</p>	<p>Chair of the Workforce Committee to 30 November 2019</p> <p>Member of the Mental Health Act Scrutiny Committee</p> <p>Member of the Nominations and Remuneration Committee</p>	<p>Governor, Selly Oak Trust School</p>

Board Member	Profile	Committee Involvement	Declared Interests
 <p>Adam Williams, Non-Executive Director</p>	<p>Adam is the Regional Operations Manager for St John Ambulance, overseeing operational activity across the West of England and supporting the charity by taking responsibility for Care Quality Commission regulation within his area of responsibility.</p> <p>Prior to operations, Adam was National Head of Volunteering at St John Ambulance driving forward the strategic approach to volunteering and driving large scale organisational change. Adam is still a current volunteer with St John Ambulance as an Emergency Medical Technician and supports the training of emergency first aid. Prior to this Adam spent over 5 years in the Youth Sector working on local and national youth work initiatives, including National Citizen Service, Local Government Association projects and overseeing the Youth in Action programme through the British Council. During this time, Adam led on Youth Participation and believes strongly in the voice and influence of young people.</p> <p>Since 2014, Adam has been a Public Governor for West Midlands Ambulance Service NHS Foundation Trust.</p>	<p>Member of the Audit Committee</p> <p>Member of the Nominations and Remuneration Committee</p> <p>Chair of the Finance and Performance Committee from 1 July 2019</p> <p>NED Lead for Emergency Planning</p>	<p>National Head of Community Response and CQC Registered Manager</p>
 <p>Simon Murphy Non-Executive Director from 1 April 2019 to 30 June 2020 Chair from 1 July 2019 to 30 September 2019</p>	<p>Simon is Chair of the Sandwell Local Improvement Finance Trust Company, a public-private partnership that builds and manages health centres. He is a Board member of the Worcestershire Local Enterprise Partnership, and also Chair of the Finance and Audit Committee of the regional employment and environment charity, Groundwork West Midlands.</p> <p>Simon has represented Dudley and Walsall as a Member of the European Parliament. He is former Director of the Birmingham Coventry and Black Country City Region, and has been a Governor of the University of Wolverhampton, as well as a University Tutor. He holds a PhD in conflict management.</p> <p>Simon is married with two children, and in his spare time are a junior rugby coach, and the manager of a girls' cricket team.</p>	<p>Simon was the Senior Independent Director (SID)</p> <p>Chair of the Finance and Performance Committee</p> <p>Member of the Quality & Safety Committee</p> <p>Member of the Nominations and Remuneration Committee</p> <p>NED lead for Duty of Candour and NED lead for Mortality</p>	<p>Chair, Sandwell Local Improvement Finance Trust Company Ltd</p>

Board Member	Profile	Committee Involvement	Declared Interests
 <p>Harry Turner, Chair From to 30 June 2019</p>	<p>Harry's professional career has been spent in the hospitality sector, managing a range of hotel groups, golf courses and leisure clubs.</p> <p>Recently he has held senior operational management positions in national and international companies such as Travel Inn (now Premier Inn), Marriott Hotels international and most recently a Director of a private equity backed takeover of Travelodge.</p> <p>Since 2008 he has held Board level positions within the NHS, he was, for 6 years, the Chair of Worcestershire Acute NHS Trust.</p> <p>He is currently a Magistrate within West Mercia, Chairman of the John Taylor Hospice in Birmingham, a Non-Executive Director at Robert Jones and Agnes Hunt Orthopaedic Hospital. He is also a steering group member on an NHS research project focused on patient experience</p>	<p>Harry was Chair of the Nominations and Remuneration Committee to 30 June 2019.</p>	<p>Chair – John Taylor Hospice, Birmingham</p> <p>Deputy Chair Worcestershire Magistrates</p> <p>Steering Group Member – NHS Research Project PEARL</p> <p>Owner – FTK Associates</p> <p>Owner – Vacation Rentals Lda Portugal</p> <p>Magistrate – West Mercia benches</p> <p>Non-Executive Director – Robert Jones and Agnes Hunt NHS Foundation Trust</p>
 <p>Mark Axcell, Chief Executive</p>	<p>Mark has been Chief Executive at Dudley and Walsall Mental Health Partnership NHS Trust since 2015 and in January 2020 was appointed Chief Executive at Black Country Partnership NHS Foundation Trust .</p> <p>During his time at Dudley and Walsall Mental Health Partnership Trust Mark significantly improved the organisation's CQC ratings, its culture and staff engagement whilst at the same time achieving financial balance.</p> <p>In 2018 Mark was shortlisted for the prestigious Health Service Journal Chief Executive of the year award.</p> <p>Mark has over 25 years' experience working in the NHS across both Primary Care, Secondary Care, Community and Mental Health Services. The majority of this has been working in the Black Country.</p> <p>Mark is a qualified accountant by background and a member of the Chartered Institute of Public Finance and Accountancy.</p>	<p>Member of the Finance & Performance Committee</p> <p>Member of the Quality and Safety Committee</p> <p>Chair of MEXt</p>	<p>CEO of DWMHP and BCP</p> <p>Sister is Advanced Nurse Practitioner in GP Practice</p> <p>Member of Organising Committee of Penkridge Cricket Club</p>

Board Member	Profile	Committee Involvement	Declared Interests
 <p>Marsha Foster Director of Operations</p>	<p>Marsha began her NHS career in 1995 via the NHS General Management Training Scheme. She then undertook a range of general management and service development posts within mental health services in Birmingham and Solihull, before project managing a number of NHS mergers.</p> <p>She was the project director for the formation of Dudley and Walsall Mental Health Trust and was then appointed as Head of Corporate Affairs for the Trust. Appointment as Executive Director of People & Corporate Development followed in March 2012.</p> <p><i>PG Diploma Healthcare Management</i> <i>BA (Joint Hons) Economics & Management Studies</i></p>	<p>Member of the Finance & Performance Committee</p> <p>Member of the Quality & Safety Committee</p> <p>Member of the Mental Health Act Scrutiny Committee</p> <p>Member of the Workforce Committee</p> <p>Member of MExT.</p>	<p>No declared interests</p>
 <p>Rosie Musson, Director of Nursing</p>	<p>Rosie has worked in the NHS since 1985, qualifying as a Registered Nurse in 1988. Rosie's career has spanned a number of clinical and leadership roles including Nurse Consultant in Acute Mental Health Services and Associate Director of Nursing.</p> <p>Rosie has an MSc in Quality Management in Healthcare and is passionate about driving quality improvement and patient safety and has a broad experience in Quality Governance.</p>	<p>Member of the Quality and Safety Committee</p> <p>Member of the Mental Health Act Scrutiny Committee</p> <p>Member of the Finance & Performance Committee</p> <p>Member of the Workforce Committee</p> <p>Rosie has the role of the Director of Infection Prevention and Control (DIPC) for the Trust.</p> <p>Member of MExT</p>	<p>No declared interest</p>

Board Member	Profile	Committee Involvement	Declared Interests
 <p>Robert Pickup Director of Finance, Performance and IM&T</p>	<p>Rob is a qualified accountant with over 15 years' experience in NHS Finance having started his career as a member of the NHS Financial Management Training Scheme. Rob has worked both in provider and commissioning sectors in senior management roles through his career.</p> <p>Prior to joining the Trust on secondment, Rob worked as Deputy Director of Finance at Birmingham & Solihull NHS Foundation Trust.</p> <p>Rob is a member of the Chartered Institute of Management Accountants and also the West Midlands branch vice chair and a member of the Mental Health steering committee for HFMA.</p>	<p>Member of the Finance & Performance Committee</p> <p>Member of the Workforce Committee</p> <p>Member of MExT</p> <p>Robert is the Senior Information Risk Owner (SIRO) for the Trust</p>	<p>Trustee at John Taylor Hospice</p>
 <p>Mark Weaver Medical Director</p>	<p>Mark grew up in the Midlands and qualified at Kings College Hospital Medical School London. Following post-graduate psychiatric qualifications in Birmingham, he was a Senior Registrar, Clinical Research Fellow and Consultant in General Adult Psychiatry at St Bartholomew's Hospital, London. He was also lecturer and examiner for the undergraduate psychiatry course, examined for the University of London final MBBS medical examinations and ran the Royal College of Psychiatrists membership course.</p> <p>Since 2004, he has been Consultant in General Adult Psychiatry in Walsall and Associate Medical Director since 2005.</p> <p><i>MB.BS London</i> <i>M R C Psych</i></p>	<p>Member of the Quality & Safety Committee,</p> <p>Member of the Mental Health Act Scrutiny Committee,</p> <p>Member of the Finance & Performance Committee</p> <p>Member of the Workforce Committee</p> <p>Member of MExT.</p> <p>Mark is the Responsible Officer for Medical Revalidation and is the Caldicott Guardian for the Trust</p>	<p>No declared interest</p>

Board Member	Profile	Committee Involvement	Declared Interests
 <p data-bbox="85 523 300 596">Ashi Williams, Director of People</p>	<p data-bbox="407 239 1310 347">Ashi has 12 years' experience working in the NHS in both Provider and Commissioning settings. Prior to joining the NHS Ashi worked in HR in manufacturing and private sector organisations. Ashi has an MSc in HR Management and Business and is also a Fellow of the Chartered Institute of Personal Development.</p> <p data-bbox="407 367 1310 475">Ashi is a member of the West Midlands HPMA Committee supporting the development of HR and OD Professionals. Ashi is passionate about ensuring people have the right skills and resources to do their jobs well and that their health and wellbeing is looked after.</p> <p data-bbox="407 494 1310 545">Ashi is a health and fitness enthusiast and completed the London Marathon in 2009, Ashi enjoys travel, would describe herself as a foodie and keen cinema goer.</p>	<p data-bbox="1332 239 1729 264">Member of the Workforce Committee</p> <p data-bbox="1332 284 1749 335">Member of the Finance & Performance Committee</p> <p data-bbox="1332 354 1518 379">Member of MExT</p>	<p data-bbox="1803 239 2168 347">Married to Accountable Officer of Sandwell & West Birmingham CCG and Black Country STP Lead</p> <p data-bbox="1803 367 2145 443">Sister employed by the Trust in the Dudley Talking Therapies Team</p>

The Board of Dudley and Walsall Mental Health Partnership NHS Trust is ultimately responsible for the actions and decisions of the organisation and notably for service delivery and quality, financial stewardship and strategic direction. It is composed of both Non-Executive and Executive Directors and meets in public in varied and accessible venues every month; the details of these meetings are publicised via the website.

Our Chair is appraised on an annual basis by NHS Improvement following a 360 degree review. Following the Chair's appraisal, a summary of the appraisal outcomes is produced and shared with the Chair.

All Non-Executive Directors are independent of the Trust and any direct business interests or otherwise must be declared. Our Non-Executive Directors come from a variety of working backgrounds and each has specific interests and skills that contribute to the overall structure of our Trust Board.

In 2012, as preparation for our transition to Foundation Trust, a shadow Council of Governors was established. Governors represent the views of the membership and have the opportunity to relay members' thoughts to the Trust Board. This important role ensures that the membership directly influences the future development of mental health services across Dudley and Walsall boroughs.

However, as the Trust's application for Foundation Trust status remained deferred and with the emergence of the TCT Partnership and the decision of all three partner Board's was taken to formally, the formalities of the Council of Governors were disbanded in October 2016. Since then the Trust has continued to engage with those former shadow Governors who wished to be engaged as Ambassadors for the Trust. Following the ending of the TCT Partnership, but the continuing work with Black Country Partnership NHS Foundation Trust towards integrating the two Trusts, that engagement will be focused on encouraging membership of the enlarged organisation and its Council of Governors.

Senior Managers Service Contracts (directors only)

The remuneration and terms and conditions for Directors who sit on the Board (except Non-Executive Directors) are set by the Nominations and Remuneration Committee. For all post holders except the Joint Medical Directors / Medical Director, the Acting Director of Nursing, the Acting Director of People and the Director of Finance Performance and IM&T the remuneration and terms and conditions are in accordance with Very Senior Manager terms and conditions. The Chief Executive's pay has been set using benchmark information for similar Chief Executive Positions in other comparable Trusts.

All Directors receive regular appraisals. The Non-Executive Directors are appraised by the Chair of the Trust, as is the Chief Executive. The other directors are appraised by the Chief Executive. The Nominations and Remuneration Committee have not determined any performance related pay arrangements or bonuses. Any inflationary pay award for those Executive Directors on Very Senior Manager Contracts is determined under the guidance from NHSI annually by the Nominations and Remuneration Committee.

All Directors are on substantive contracts of employment. The Chief Executive is subject to a six-month notice period as are all other Directors who are on very Senior Manager Contracts of Employment. Any termination payment would be determined in line with the standard NHS redundancy payment scheme, where appropriate. No termination payments have been made during the reporting period.

There are no other additional benefits that will become receivable by a senior manager in the event he/she retires early. It is customary that staff retiring from service within the Trust or NHS have their contribution recognised in the form of a gift and/or leaving event. Staff are given a gift with a maximum Trust contribution of £100, in accordance with the Trust Retirement Policy.

4.1.1 *Board and Committees*

The Board has established a number of Board Committees to ensure good Board governance and a focus on specific key strategic themes. These committees are:

The Nominations and Remunerations Committee advises the Board on appropriate pay and terms of service for all Board level posts, excluding the Chair and Non-Executive Directors whose pay and terms of service are set by NHS Improvement (NHSI). The Nominations and Remuneration Committee is chaired by the Trust Chair and comprises all the Non-Executive Directors and Associate Non-Executive Directors. The Committee meets on a quarterly basis.

The Mental Health Act Scrutiny Committee has delegated authority to oversee the management and administration of the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and their respective codes of practice. The committee is responsible for monitoring compliance and to consider issues in relation to the use of the mental health legislation throughout the Trust to identify areas of risk and monitor mitigating actions accordingly. The Mental Health Act Scrutiny Committee is chaired by Debbie Nixon, Non-Executive Director. The other substantive members of this Committee are Tracey Orr, Associate Non-Executive Director, the Director of Operations, the [Joint] Medical Director(s) and the Director of Nursing. The Committee meets on a quarterly basis.

The Audit Committee which provides an independent and objective view of financial systems and governance, financial information, assurance processes and compliance with regulations governing NHS Trusts. The Audit Committee is chaired by John Lancaster Non-Executive Director and to maintain its independence the other members of the Committee are Non-Executive Directors.

The Auditor Panel which has been established by the Trust, in accordance with the Local Audit and Accountability Act 2014 and constituted with the same membership as the Audit Committee to provide advice on the appointment of external auditors which became the responsibility of the Trust for the financial year 2017/18, advise the Board on their removal or resignation and also advise on the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor.

The Finance and Performance Committee is responsible for reviewing the Trust's performance against key financial and operational targets. It is also responsible for reviewing the Trust's key financial strategies and policies. The Finance and Performance Committee was chaired by Dr Simon Murphy, Non-Executive Director to June 30 2019 and then by Adam Williams to 31 March 2020. The other substantive members of this Committee are John Lancaster, Non-executive Director, the Chief Executive, the Director of Finance, Performance and IM&T, the Medical Director the Director of Operations, the Director of Nursing and the Director of People. The Committee meets on a bi-monthly basis.

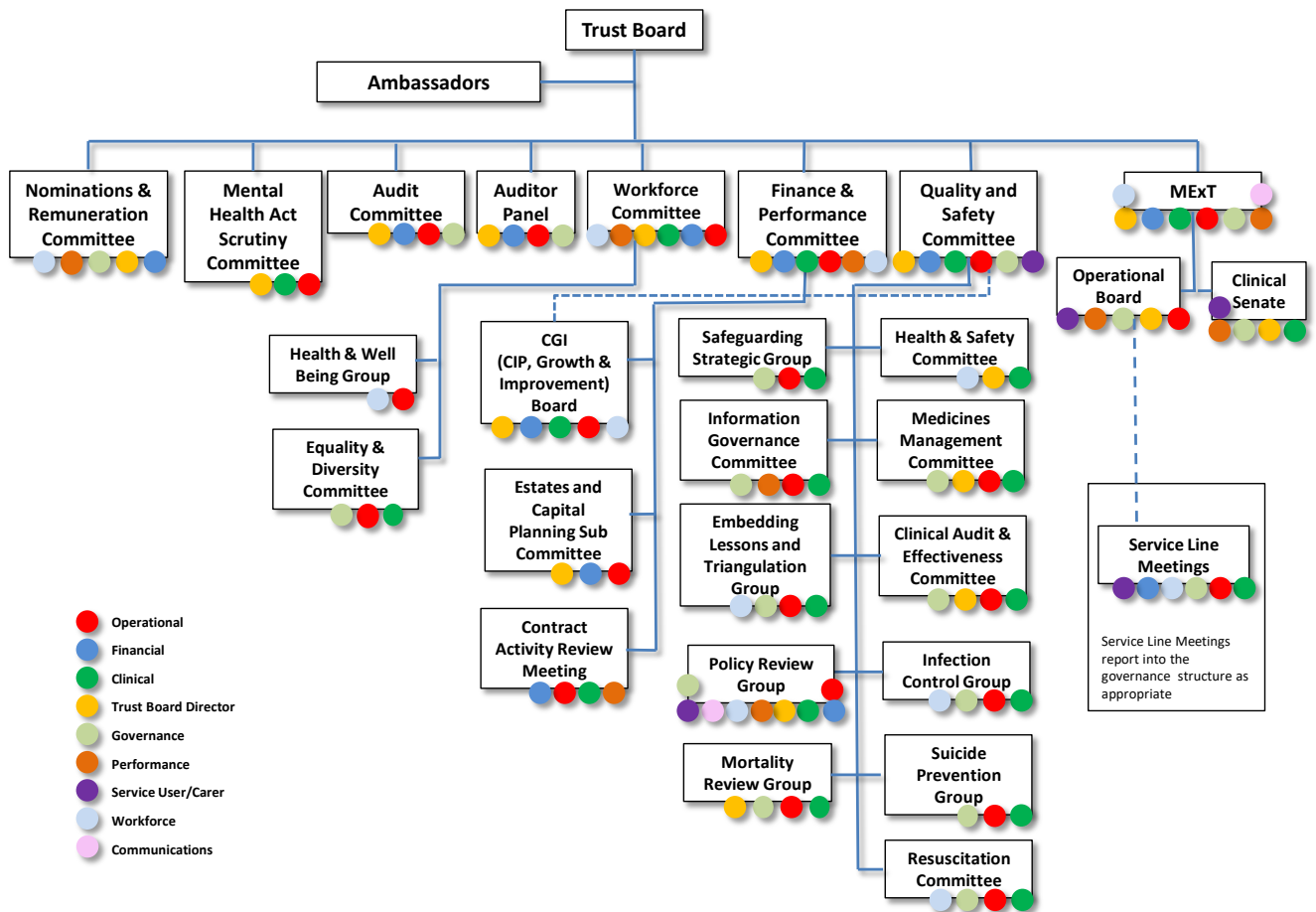
The Quality and Safety Committee is responsible for reviewing and maintaining effective systems for integrated governance, risk management and internal control across all of the Trust's activities, both clinical and non-clinical. The Quality and Safety Committee was chaired by Christine Fearn, Non-Executive Director to 30 December 2019 and then by Debbie Nixon from 1 January 2020. The other substantive members of this Committee were Dr Simon Murphy, Non-Executive Director, Adam Williams, Non-Executive Director, the Chief Executive, the Medical Director, the Director of Nursing and the Director of Operations. The Committee meets on a bi-monthly basis.

The Workforce Committee is responsible for ensuring that that there is a coordinated strategic response to the workforce needs of the organisation and ensure the delivery of the Trusts strategic objectives in relation to "People" and ensure that there is an appropriate response to the strategic workforce risks and performance against workforce standards and key performance indicators. The Workforce Committee was chaired by Tracey Orr until 30th November 2019 and then Chris Fearn from 1st December.

The other substantive members of this Committee are the Director of People, the Director of Nursing, the Director of Operations, the Director of Finance, Performance and IM&T and the Medical Director. The Committee meets on a bi-monthly basis.

Management Executive Team (MExT) operates as the Trust's 'Strategic and Operational Board' and oversees all day-to-day matters of operational, strategic and corporate significance. MExT is chaired by the Chief Executive the other substantive members of MExT are the Director of Finance, Performance and IM&T, the Medical Director, the Director of Operations, the Director of Nursing, the Director of People, Clinical Services Director, the Clinical Directors, the Chief Pharmacist, the Head of Compliance and Patient Safety and the Head of Communications. The Committee meets on a bi-monthly basis.

Figure 46 Board and Committees



4.1.2 *Composition of Management Executive Team (MExT)*

The management executive team comprises:

- **Chief Executive Officer (Chair)**
- Director of Operations
- Director of Finance, IM&T & Estates
- Director of Nursing
- Medical Director
- Director of People
- Chief Pharmacist
- Deputy Director of Finance
- Communications & Engagement Manager
- Head of Financial Planning
- Associate Medical Directors
- Company Secretary
- Clinical Service Director
- Associate Director, Corporate Development
- Associate Director of Nursing

4.1.3 *Names of Directors forming Audit and other committees*

These are included in the profiles within Board Directors 2019/20.

4.1.4 *Details of company directorships and other interests*

These are included within section 4.1.

4.1.5 *Statement that Directors are satisfied that the adoption of the going concern basis is not in doubt*

The Board of Directors is satisfied that the Trust is not about to take or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency and is therefore satisfied of the adoption of a going concern basis.

4.1.6 *Statement as to disclosure to auditors*

As far as the Directors are aware, there is no relevant audit information of which the Trust's Auditors are unaware. As a Board of Directors, we have taken all appropriate steps to make ourselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

4.2 Information Governance

4.2.1 *Disclosure of Personal Data Related Incidents*

In 2019/20, the Trust has experienced 1 reportable IG related incident which was reported to the ICO, this incident was reviewed by the ICO's Criminal Investigations Teams as it involved an individual who breached the Data Protection Act 2018 rather than a direct breach within the Trust, the ICO outcome was that no further action would be taken in relation to the individual and that the Trusts had appropriately secured the information, put in place preventative measures and contained the incident.

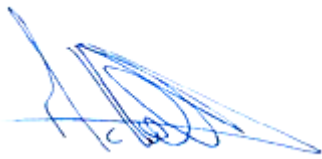
The process the Trust adopts when incidents do occur is that the person who has caused / noticed the breach notifies their line manager and records the incident on the Trust's incident reporting system (Safeguard). The Data Protection Officer reviews each incident in line with the IG risk matrix. If the score/severity of the breach warrants it, the Data Protection Officer would register the incident within the Data Security and Protection Toolkit which would automatically alert the ICO, following this the SIRO, the Caldicott Guardian and the Clinical Governance and Human Resources (if required) Department would be made aware of the incident.

4.3 The Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.



Signed

Mark Axcell Chief Executive

Date: 24 June 2020



Signed

Paul Assinder Chief Executive

Date: 24 June 2020

4.4 Statement of Director's Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

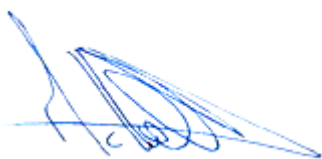
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board



Signed

Mark Axcell Chief Executive

Date: 24 June 2020



Signed

Paul Assinder Chief Executive

Date: 24 June 2020

4.5 Annual Governance Statement

4.5.1 *Scope of responsibility*

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

4.5.2 *The purpose of the system of internal control*

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Dudley and Walsall Mental Health Partnership NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Dudley and Walsall Mental Health Partnership NHS Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

4.5.3 *Capacity to handle risk*

The management of risk is everybody's responsibility within the Trust. Risk management forms an aspect of the "introduction to Governance" training provided as part of the Trusts package of induction training. In line with the wider improvements to the Trust's staff induction format in 2019/20 rather than a formal presentation there will be a series of "market stalls" where a number of teams will talk about their roles, one of which will be the Compliance and Safety Team which will include a talk on Risk Management in the organisation. All staff should familiarise themselves with the risk management process be aware of risks within their working environment and identify any new risks to their line manager. Risks are identified through the Service Line Meetings and are owned and managed by the services.

The Trust Board retains overall responsibility for ensuring that appropriate risk management systems are in place to enable the organisation to deliver its objectives. Board Committees and Sub Committees / Groups through the parent Committee have the responsibility to provide assurance to the Board that risks within its remit are being identified and managed appropriately.

I have overall responsibility for the Trusts risk management programme and for ensuring that this system operates effectively. The Executive Directors are responsible for ensuring that there are appropriate processes for risk management within the directorate.

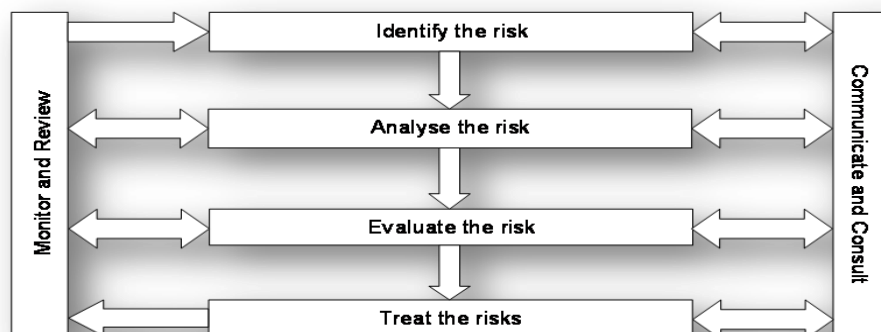
The Trust adopts a structured and pragmatic approach to risk management training and will provide a comprehensive programme of risk management training.

All board members and senior managers (those with a responsibility for a tier 3 directorate risk register undergo specialist risk management training on a 12 monthly basis as a mandatory requirement.

4.5.4 The risk and control framework

The process of risk management in the Trust, graphical demonstrated below is a continuous process and involves the identification, evaluation and treatment (mitigation) of risks, aiming to reduce either the severity or the likelihood of a risk occurring.

Figure 47 Risk Management Approach



The Trusts risk management strategy sets out the Trusts risk management arrangements, defining a framework that enables the effective management of these risks and in particular those relating to the achievement of strategic, corporate and clinical objectives. Specifically the strategy:

- Provides a framework for proactively identifying uncertainties in order that risks can be mitigated and opportunities to eliminate and prevent risks utilised
- Provides systems and structures for identifying, assessing, prioritising managing, and reporting risk in a consistent manner across all services in the Trust
- Facilitates the development of an embedded culture of safety awareness throughout all levels of the Trust
- Provides a framework from which meaningful risk metrics can be provided to the Trust Board, Senior Management and Service Lines
- Provides a framework for assurance to the Trust Board and senior management that risks are being appropriately identified, appraised, managed and monitored
- The use of a robust framework allows the organisation to identify, assess, record, prioritise and escalate risk in a systematic and consistent manner, thus allowing risks to be managed to a level which is seen as acceptable. The Trust uses a structured approach to risk identification and assessment, and the subsequent collation, prioritisation and management of risks at both an organisational and local level.

Risk appetite in the Trust represents a balance between the potential benefits of innovation or change and the threats that this innovation or change will potentially bring and is circumstance dependent and therefore individually assessed. The Trust's identification is twofold. Target risk scores are established for all risks and are a means of expressing a target for the lowest acceptable (tolerated) level for that risk. A trigger score has been set, currently that is a risk score of 15 or above which automatically trigger a discussion via the risks held on the Trust Wide Risk Register.

Risks are identified through a variety of external and internal sources and the Trust takes the widest possible approach to the identification of risks, with risks identified at all levels throughout the organisation. On identification of a risk, the current controls in place to mitigate the risk are assessed and the risk is allocated a risk rating using a matrix and agreed likelihood and severity (consequence) descriptors.

This prioritisation tool (risk matrix) is based upon the Australian and New Zealand Risk Management Risk Management Standard (AS/NZ 4360:1999).

The matrix below is used to assess both the initial and residual likelihood and severity of identified risks, providing an overall risk rating.

Figure 48 Overall Risk Rating Matrix C (Severity) x L (Likelihood) = Risk Score

		Severity (Consequence)				
		1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Likelihood of Occurrence	1 Rare					
	2 Unlikely					
	3 Possible					
	4 Likely					
	5 Almost Certain					

For identified risks, a programme of actions is agreed to manage and control the risks. The Trust uses the following approaches to risk control:

- Reduce/mitigate - The taking of action to reduce risk as far as is possible, either through reducing the likelihood of the occurrence or reducing its severity
- Eliminate - The taking of action to completely eliminate the risk of the occurrence
- Avoid - Whether a particular task can be undertaken in a different way so that the risk does not occur
- Transfer - The movement of risk from one party to another (department/individual/ organisation)
- Acceptance/Retention - If the risk is small or cannot be reduced, eliminated, avoided or transferred the Trust will need to accept it and prepare an action plan to avoid its exposure. Action plans are developed to set out the steps required to manage each risk. Where additional resources are required to effectively manage a risk, this is linked into the Trust's business planning process

Along with a robust structure/framework for risk management, the Trust's risk management strategy is further underpinned through effective communication of risk including the use of risk registers. The use of a robust framework allows the organisation to identify, assess, record, prioritise and escalate risk in a systematic and consistent manner, thus allowing risks to be managed to a level which is seen as acceptable. Risks are therefore escalated in accordance with their risk score and as such a tiered approach to this is taken in accordance with the following framework. In addition to this risks are also presented to a variety of meetings and committees for oversight.

4.5.5 Developing Workforce Safeguards recommendations

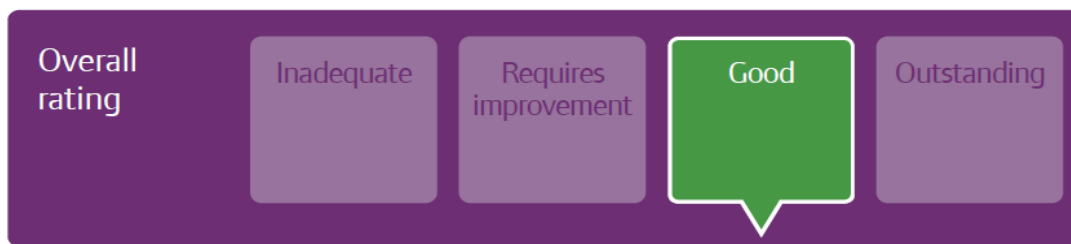
The Trust must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively and should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using services and keep them safe using an approach that reflects current legislation and guidance A nurse establishment and skill mix review was conducted during the year and the Trust is revising its Workforce Strategy through the Workforce Committee for Board approval.

Within the Trust wide parameters agreed by the Board, decisions regarding the safe staffing levels on Wards are taken on the basis of risk Implementing an acuity tool and safe care, which is a systematic approach to calculating number of staff required against acuity and professional judgment regarding the safe staffing levels on wards with the support of the Trust's E-Rostering system. Staffing and skill mix is displayed on Wards. The Trust has a Safer Staffing Escalation Framework and a mature incident reporting process and culture reported through the Quality and Safety Dashboard.

Compliance with the Trust's Safe Staffing indicators is included in the Integrated Performance Report and a more detailed analysis of planned and actual staffing, exception reporting for variances and concerns relating to safer staffing, trends in monthly average fill rate, Bank and agency actual hours' against substantive hours and the number of Qualified staff per shift is reported to Workforce Committee on a monthly basis and then onto Board through the Workforce Report.

The Trust was inspected by the CQC in January 2020; the inspection team reviewed one core service (acute wards for adults of working age) and completed a Trust-wide Well-Led assessment. The findings of the inspection were published on 30th March 2020; the organisation maintained an overall 'Good' rating across all five quality domains; this was a real achievement reflecting the hard work of staff across the Trust. The matrix below shows the detailed ratings:

Figure 49 CQC rating



	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Outstanding	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good

Overall trust quality rating	Good ●
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Good ●
Are services well-led?	Good ●

In its inspection of the Trust, the CQC rated the services well-led through evidence that leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Senior leaders understood the challenges to quality and sustainability the trust faced, with workforce, and service delivery, as key challenges. They were able to explain clearly the actions they had taken and the plans they had in place to further address those challenges. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. It was highlighted that the Trust was committed to improving services by learning from when things go well and when they went wrong, promoting training, research and innovation and enabled learning across the Trust.

Importantly staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

There are no conditions attached to the Trust's CQC registration, therefore the trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust understands that there are improvements to be made and has developed an improvement action plan and is actively working towards an outstanding rating.

The Trust has also maintained a Sector 2 banding within the Single Oversight Framework.

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

4.5.6 Quality Governance

Quality Governance in the Trust is the combination of structures and processes at and below board level to lead on trust-wide quality performance including:

- ensuring right standards are achieved;
- investigating and taking action on substandard performance
- planning and driving continuous quality performance
- identifying, sharing and ensuring delivery of best practice; and
- identifying and managing risks to quality of care

The Trust reports at all levels within the organisation regarding quality of care, culminating with detailed information to the Trust's Quality and Safety Committee and the Trust's Board. Quality within the Trust is embedded from the BAF, where the risk to achieving quality of care is identified as a risk and action is monitored. All targets can be tracked through Board reporting, with clear progress identified against each objective along with clear risks to their achievement and mitigation to be undertaken. The Trust also has a number of mechanisms in place to review lessons learned from enquiries and capture actions from internal and external reviews. Mechanisms include the Embedding Lessons and Triangulation Group and the Clinical Audit Effectiveness Committee (CAEC), which report through the Quality and Safety Committee.

The Trust has received one Regulation 28 prevention of future death reports during the year.

Data quality is subject to internal review with actions taken where appropriate. At each Quality and Safety Committee and Board meeting a report is provided on progress against quality of care standards.

The Trust has processes in place to ensure the engagement of staff, patients, carers and other stakeholders in the consideration of the quality of care, with various groups established to facilitate this. The Trust's Experts By Experience have a comprehensive work programme and regularly report on their activity and observations around the quality and safety of the care afforded to the Trust's patients to the Quality and Safety Committee.

The Trust's strategy sets out a focus on continuous improvement and the strategy contains reference to a number of Trust wide quality improvement priorities and CQUINs. The Trust has continued to deliver an annual programme of quality improvement which includes the nationally defined CQUINs. The process to deliver this has been applied across the Trust and also for each service line to address key areas of risk and is in line with the strategic direction of Trust.

Areas for improvement have been based on continuous intelligence about the quality of service, including from performance data, incidents, internal audits, clinical audit, appreciative enquiries, service user and stakeholder feedback. Improvement Plans have been developed on a project management approach, with assurance on the delivery of those plans being given to the Trust Board through its Quality & Safety Committee. Measurement is through both quantitative and qualitative methods. Metrics enable the trust to identify variations against plans and targets, provide analyses and commentary on performance, and enable review of projections and trajectories and risks to achieving these.

Improving the use of metrics has focused on accuracy, timeliness, completeness and reliability of data and measures in line with the Trust's Data Quality Policy and their increased use at Service, Team and Individual level through the quality improvement education programme.

The Trust seeks assurance that it complies with the CQC registration requirements through the work of the Trust's CQC Steering Group. The Group is central in the development and monitoring of the any action plans developed in relation to CQC compliance and CQC Mental Health Act Visits. The Trust also undertakes compliance / supportive visits which review services against set criteria / standards aligned to the CQC standards outlined within the CQCs registration requirements.

Action plans are developed in relation to the outcomes of these compliance / supportive visits which are reviewed and monitored by Trust's CQC Steering Group.

The Trust has an Incident, Near Miss and Serious Untoward Incident Policy; any events falling under the definition of the policy are reported and managed through the Trust's online incident reporting system. The policy clearly requires all staff to report incidents as soon as practicable. Considerable work continues to be undertaken by the Trust's Staff Engagement Lead working with engagement champions across the organisation to encourage the reporting of incidents to enable the trust to learn and continual improve the delivery of safe quality services to its patients.

The Trusts Compliance and Safety Team actively engages with the Trust's clinical teams to provide advice, guidance and training in relation to the incident reporting system where required and regularly provide feedback, sharing trends and analysis to appropriate Committees and Individuals. Incident reporting is also discussed as part of the Trusts induction training and is also included on a number of other training programs, such as nursing preceptorship and band 5 and 6 nursing development sessions.

The Trust promotes a just culture and during 2019/20 it continued to strengthen the multi-disciplinary approach to Serious Incident investigation to improve the application of Root Cause Analysis and in turn the learning from incidents.

In 2019/20, all major service development and redesign projects were managed through project management principles supported by an electronic software solution, embedding Quality Impact Assessments (QIA's). The Trust has an effective Quality Impact Assessment process in place to ensure that quality of care is not compromised through its Cost Improvement Plans. Quality and Equality Impact assessments have been completed for all service transformation developments and cost improvement programmes. QIAs are designed to ensure that service transformation plans place quality and safety improvement as the highest priority.

These assess the potential positive impacts on quality and detail the measurement methodology. They also identify any potential risks to quality and describe how these risks will be mitigated. Quality Impact assessments are linked to the 6 strategic quality objectives in the Trusts Quality

Improvement Strategy. These are signed off by the Director of Nursing and Medical Director and assurance given to the Quality and Safety Committee before schemes are presented to Board for discussion and approval.

This helps to ensure that quality and safety issues are robustly debated before presentation to Board. Mechanisms exist within the Trust to ensure the impact of initiatives on quality is measured on an ongoing basis and that mitigating action is taken where necessary and reported through the Trust's governance structure. Project closure documentation includes any residual risks moving into business as usual.

Data Protection Impact Assessments are also being embedded within the process in accordance with the General Data Protection Regulations (GDPR).

The Trust continues to encourage the sharing of best practice and innovation. Whilst this will take place within the operations of the services the Trust's embedding lessons and Triangulation Group supports and promotes the sharing of learning across the organisation.

4.5.7 Major Risks

The Trust has an organisational strategy that supports its' Clinical and Social Care Strategic Vision, resulting in a clear "strategy on a page" linking the Trust's vision and values into strategic domains which feed into annual corporate objectives.

Risks to the achievement of the strategy are managed through the Board Assurance Framework (BAF) whilst organisational risks identified are managed through the high level corporate risk register.

The strategic risks are clearly identified and inform the BAF. Board members are able to comprehensively describe the same set of risks facing the organisation.

The Trust Board receives assurance on key issues from each Committee the impact of the risks on the Trust's strategic aims and objectives being monitored quarterly by the Trust Board's Committees to provide assurance to the Board on the effective management of the strategic risks to the organisation. The process by which this happens is monitored through the Audit Committee.

The Board Assurance Framework included five strategic risks, these are outlined below and there is further detail elsewhere in the Trust's annual report. These strategic risks continued from the previous year.

Figure 50 Strategic Risks

RISK REFERENCE	Risk Description
SR1	Sustainability of the Organisation
SR2	Long Term Financial Sustainability
SR3	Achieving quality of care
SR4	Ability to recruit and retain staff
SR5	Management, Maintenance and Strategy for the Estate
SR6	Impact of the BCP / DWMH Integration on the ongoing delivery of services

The Trust's BAF underpins the delivery of its key objectives and incorporates the highest risks faced by the organisation. It therefore aligns the Trust's principal risks with the key controls and assurances for each of the Trust's key objectives. Where gaps in assurances are identified, mitigating actions are developed to reduce the risk of the non-delivery of these key objectives.

I am satisfied that corporate governance systems in place are appropriate.

The Trust had an operational plan developed and approved by the Board for 2018/9. The monitoring against delivery of this plan occurred through the committees of Board on a regular basis through the business cycle of reporting and has been triangulated by the internal audit programme and other mechanisms including visits to clinical areas, wards and departments.

The Trust has in place a robust governance framework that includes the Standing Orders, Standing Financial Instructions and a Scheme of Delegation, which along with the Committee Terms of Reference provide the mechanisms to support effective Board and committee structures, clear responsibilities for the Board and committees.

I and the Executive Directors (both voting and non-voting) who report to the Board are suitably qualified, both professionally and through experience. A robust process is in place to ensure compliance with the Fit and Proper Persons Regulations.

Our Chairman set objectives for the Chief Executive and Non-Executive Directors for 2019/20. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2019/20. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively.

There are no acting or interim arrangements within the Executive Director team.

Robert Pickup, Director of Finance, Performance and IM&T continued his secondment role on and was made substantive in 2019.

Following the end of the TCT Partnership, both the mental health trusts in the partnership gave a commitment to continue the positive work that had begun under that partnership. In June / July 2018 both Trust's signed a Memorandum of Understanding to work together to identify opportunities to enhance the qualitative and economic sustainability of the services they separately provide and to collaborate to develop services not currently provided including the consideration of alternative and jointly provided models of care and the most effective form of delivery and in autumn 2018 the Board confirmed its belief that the work of the two Trust's, subject to a robust clinically led business case would result in a formal transaction integrating the two Trusts. A Strategic Case was submitted to NHSI in January 2019 and the two Trusts have continued to work to an integration date in April 2020.

It is against this background that as a proxy measure of the effectiveness of the Board's leadership the Trust delivered a surplus, maintained performance against its Key Performance Indicators and received some very positive results through the Staff Survey.

There has been a process in place to further develop the service lines within the Trust to support delivery and accountability, with a revised service line structure being implemented from 1 April 2019. All staff have access to performance information dashboards. Each division has its own governance structure and is responsible for gaining assurance on performance including quality indicators of their service. Service level meetings help foster a culture whereby learning points can be noted and shared through the Management Executive Team.

Appropriate governance structures are in place to support working towards compliance with healthcare standards, in particular through the Quality and Safety Committee and its sub Committees. A CQC Steering Group has continued to operationally lead the delivery of the CQC action plan following the Trust's inspections overseen particularly by the Quality and Safety and Mental Health Act Scrutiny Committees.

A CQC Steering Group has continued to operationally lead the delivery of the CQC action plan

following the Trust's inspections, overseen particularly by the Quality and Safety and Mental Health Act Scrutiny Committees. The one significant area of work to conclude is the implementation of a revised Electronic Patient Record.

The considerable work undertaken by the Trust in 2016/17 to procure a new Electronic Patient Record was appropriately put on hold, with a view to aligning systems across the partner Trust's under the TCT Partnership in anticipation of the integration of the three Trusts. When the partnership and the acquisition was stood down a new approach to quickly mobilise the procurement of a new EPR was developed. The contract for a new EPR was finalised and the new system began implementation in 2019/20 in partnership with BCPFT.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

4.5.8 Review of economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I am responsible for ensuring that the Trust has arrangements in place for securing value for money in the use of its resources. To do this I have maintained systems to:

- Set, review and implement strategic and operational objectives
- Engage actively with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon
- Monitor and improve organisational performance
- Establish plans to deliver cost improvements.

The Trust submits to NHS Improvement (NHS I) an Annual Plan incorporating a supporting financial plan approved by the Board of Directors. This informs the detailed operational plans and budgets which are also approved by the Board. The Trust actively engages Commissioners, NHS Improvement and others as necessary to develop and agree detailed financial and operational plans. Prior to approval the Board takes the views obtained from stakeholders into account.

The Board agrees annually a set of corporate objectives and milestones which are communicated to colleagues. Achievement of those milestones is reviewed on a quarterly basis.

Operational performance is kept under constant review by the Executive Team and Board of Directors.

External Audit undertake Value for Money (VFM) reviews as part of the governance arrangements to ensure the Trust is delivering against its financial requirements. As part of the VFM review audit concluded that the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources except for in relation to the management arrangements for the Electronic Patients Record system (Rio). As such, a qualified 'except for' VFM conclusion is anticipated with all other aspects around use of resources adhering to requirements.

4.5.9 Performance Management Reporting

To ensure that the Board is aware to a sufficient degree of what is happening across the Trust, a comprehensive Integrated Performance Report and Dashboard is reviewed at each monthly public Board meeting. The report is structured across the domains of Quality, Finance and Workforce. This includes outcome and quality governance measures and performance indicators rated red, amber or green. Importantly the quality and performance report includes information on 'Serious Incident' and 'never events' and the Trust Board receives information on follow-up action.

The Trust keeps under review the indicators by which it monitors its quality financial, operational and workforce performance.

The Trust has clear performance reporting on Human Resource issues and through performance management reporting the Board are sighted on service level achievement of targets for statutory and mandatory training, appraisal details and levels of sickness.

This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include: patient and staff stories to Board and 'Experts By Experience' (EBE) reflections, which are presented quarterly. Board members also carry out programmed On Board Walks. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement.

These arrangements allow Board members to help model our values through direct engagement, as well as ensuring that Board members take back to the boardroom a better understanding of the lived reality for staff, public and patients.

4.5.10 Cost Improvement

The Trust designs annually a programme of Cost Improvements to drive efficiency and the transformation in services across the Trust. The Trust achieved £2,133k of the £2,133k target for its programme in 2019/20, albeit not all recurrently.

4.5.11 The Role of the Board and its Committees

The Trust Board is held accountable by the Department of Health on behalf of the Secretary of State to ensure effective financial stewardship through value for money, financial control and financial planning and strategy and to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken where necessary.

The infrastructure of the Board and its Committees, which has been considered and revised periodically to reflect independent review and revised regulatory guidance has a key role in ensuring that resources are used economically, efficiently and effectively and currently comprises:

Figure 51 The role of committees

Committee	Role/ Function	Frequency
Trust Board	Retains overall responsibility for setting strategic direction, monitoring the delivery of strategic objectives and ensuring that appropriate risk management systems are in place. It sets the risk appetite for the organisation in relation to new business cases and the balance between potential benefits of innovation or change and potential threats.	Bi-Monthly

Quality and Safety Committee	The Committee holds the delegated responsibility for ensuring that clinical and operational risks are managed appropriately. It has an overview of service quality, patient experience, clinical audit, patient safety and incident management. The Committee also scrutinises the assurances associated with the development and sign-off of the Trust's Quality Governance Assurance Framework and Quality Account.	Bi-Monthly
Audit Committee	The Committee provides an objective opinion to the Trust Board on whether there are effective internal control systems in place within the organisation. It also presides over the internal audit programme which verifies the suitability and effectiveness of internal controls in respect to risk management.	Quarterly
Auditor Panel	Established by the Trust, in accordance with the Local Audit and Accountability Act 2014 and constituted with the same membership as the Audit Committee to provide advice on the appointment of external auditors which will become the responsibility of the Trust for the financial year 2017/18, advise the Board on their removal or resignation and also advise on the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor.	As required
Finance & Performance Committee	Reviews the Trust's financial management and performance , makes recommendations and provides advice to management and the Trust Board. It is also responsible for reviewing the Trust's performance against key financial and operational targets and for reviewing key financial and performance strategies. It has the authority to require the attendance of any officers of the Trust and hold them to account for financial and operational performance.	BI-Monthly
Workforce Committee	This Committee holds the delegated authority for ensuring that there is a coordinated strategic response to the workforce needs of the organisation and ensure the delivery of the Trusts strategic objectives in relation to "People" and ensure that there is an appropriate response to the strategic workforce risks and performance against workforce standards and key performance indicators	Bi-Monthly
Mental Health Act Scrutiny Committee	Oversees and scrutinises the use of the Mental Health Act within the Trust. It oversees the functioning of the Mental Health Act Lay Managers.	Bi-monthly
Nominations and Remuneration Committee	Holds responsibility for reviewing and agreeing executive terms and conditions and receives executive appraisals	As required (at least annually)
Management Executive Team (MExT)	Oversees all significant operational issues and their delivery within the Trust. It provides executive and senior management input and discussion into key decisions to implement Trust strategy. It provides a forum in which senior managers can formally raise and discuss concerns and issues.	Bi-Monthly

A review of the Governance Structure has taken place during the year. In order to further support delivery and accountability within the Trust and facilitate an increased emphasis on the Board's Strategic role from 1 April 2019 two additional meetings were established under a revised Management Executive Team – the Clinical Senate meeting monthly bringing together the clinical voice from across the organisation in leading the development of our services and ensuring that the Trust's clinically led approach as an organisation continues to grow. The Operational Board also meets monthly is responsible for operational delivery of all services.

This innovation will enable the existing Management Executive Team to have a more strategic focus on moving the organisation forward, the trust wide priorities, strategic partnerships and oversight of organizational wide programmes. Trust Board and its Committees currently meeting monthly will move to bi-monthly meetings with a programme of strategic development sessions arranged in the months the Board will not formally meet.

4.5.12 Internal and External Audit

During the year, a comprehensive programme of internal audit work has reviewed a wide range of issues and has contributed significantly to the framework of assurance.

There are no significant control issues (as defined by HM Treasury) that have been highlighted as a result of these programmes of work. External Audit had not identified any control weaknesses; however internal audit identified some Level 2 Audit Recommendations.

These are recommendations where a system has been subject to high levels of risk or has prevented the system from meeting its objectives and may have impacted on the Trust from meeting its objectives and which were included in the following reports:

Moderate assurance was given around Duty of Candour following a review in July 2019 of the Duty of Candour policy and the Incident and Serious Incident Investigation policy. The audit found that whilst incidents were appropriately classified and investigated in line with CQC and statutory guidance it was found that there were weaknesses in the Trust keeping written records of face-to-face meeting with patients or their representatives, as not all meeting had been properly recorded in accordance with the CQC and statutory guidance

Limited assurance was given around data quality in a review for Early Intervention in Psychosis. The review undertaken in December 2019 had identified weaknesses in the supporting data for Board reporting around the KPI, namely around the use of referral date rather than the date the case was seen/closed. It was identified that local and national reporting was at odds as guidance was not being fully complied with.

Internal Audit Findings

Audit noted a number of significant weaknesses in the supporting data for Board reporting for the indicator. The most significant of which being that Board reporting population of Early Intervention in Psychosis(EIP) has been produced using the referral date rather than the date the case was seen/closed therefore missing in reporting cases that may be opened in one period then closed in a future period. National reporting is taken from MHDS submissions at an aggregate level and captures closed cases in line with the guidance.

Audit also noted cases that had did not have all the required fields completed to stop the clock in the national dataset. Some of these cases would have been incorrectly continuing to be recorded as on the waiting list in national reporting. Whilst the Board do not receive information on the waiting list it is captured in National data. It is therefore no surprise that the national reporting differs from the local reporting as the local reporting has not been produced in accordance with the guidance. National reporting is reported in aggregate using Unify from the Mental Health Minimum data sets.

In March 2020 a full data cleanse and review was undertaken and improvements in training and reporting of key data in an accurate and timely manner was well underway. Improvements were also made to the internal reports used by the service to monitor and report on patients waiting – this will allow better management of waiting times.

From an External audit perspective the following areas of potential risk had been identified for the Trust (and indeed for all Trusts) that would require special audit consideration:

- Revenue for patient care activities – ensure the Trust is correctly accounting for income from patient care activities against the need to manage budget restraint against increasing patient demand and cost pressures.
- Management override of controls – ensure that estimates and transactions are effectively managed and are reasonable.
- Valuation of Land and Buildings.

- Going Concern – being reviewed in light of the transfer of some services over to Dudley Integrated Health and Care as from 1st April 2020.

There were also two Value for Money considerations identified for the Trust in relation to:

- Financial sustainability and delivery of CIP recurrently.
- Management arrangements for the transfer of services to Black Country Partnership NHS Foundation Trust.

4.5.13 Information governance

Throughout 2019/20 the Trust continued with a Joint Data Protection Officer, under an SLA with Black Country Partnership NHS Foundation Trust (BCPFT). The Data Protection Officer is undertaken by the Head of Information Governance and Data Protection, the Data Protection Officer is supported by the Trusts Information Governance Team. The roles of Caldicott Guardian and Senior Information Risk Officer are undertaken by the Medical Director and Director of Finance respectively, and the job requirements of other key corporate officers include relevant responsibilities associated with information and data security.

From October 2019 the Trusts Information Governance Committee amalgamated with the same committee within BCPFT to enable shared learning and resources to enable greater assurance within Information Governance and Data Protection. The Group consists of core members required for quoracy which are the Trusts Senior Information Risk Officer, Data Protection Officer and a Cyber Security Manager, in addition the membership of the group includes the Caldicott Guardian who joint chairs the Committee along with the SIRO from BCPFT. During the year the Information Governance Committee reviews assurance and compliance with the Data Security and Protection Toolkit and monitors the Trust wide information governance action plan on a monthly basis

Data Security and Protection Toolkit Self-Assessment Assurance

The Trust submitted its second Data Security and Protection Toolkit (DSPT), the Toolkit had been updated and there were an additional 12 Mandatory Requirements and 14 Optional Requirements. Due to the COVID-19 pandemic Trusts were provided a time extension to submit the completed DSPT requirements; however due to the pending amalgamation of services from Dudley and Walsall Mental Health NHS Trust and the organisational change it was agreed to complete the DSPT in line with original timescales.

The below table shows the submitted DSPT for Dudley and Walsall Mental Health NHS Trust:

Figure 52 DSPT submission

2019/20	Completed	Items Not Met	% complete
Mandatory Requirements	112	0	100%
Optional Requirements	15	48	23.8%
Totals	127	48	72.6%

The above was submitted with the action plan around Business Continuity in place; as the Trust will utilise the documentation and actions completed as part of the COVID-19 response as part of the evidence to show how the Trust manages Business Continuity.

Data Breach Incidents

Any incidents and/or risks associated with data and information security are reported and dealt with in accordance with the Trust risk management and incident reporting policies.

In 2019/20, the Trust has experienced 1 reportable IG related incident which was reported to the ICO, this incident was reviewed by the ICO's Criminal Investigations Teams as it involved an individual who breached the Data Protection Act 2018 rather than a direct breach within the Trust, the ICO outcome was that no further action would be taken in relation to the individual and that the Trusts had appropriately secured the information, put in place preventative measures and contained the incident.

4.6 Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Publication of the 2019/20 Quality Account will take place later in the year in line with revised national timescales, due to impacts of the Covid-19 pandemic.

The Trust's Quality Account is based on the Quality Account Toolkit published in 2010/11, additional guidance published by the Department Of Health in 2013, the NHS (Quality Accounts) Amendment Regulations 2017 and additional Quality account considerations and guidance for 2018/19 and 2019/20 issued by NHS Improvement.

The Quality Account is subject to scrutiny throughout the year through internal performance and quality governance processes, for example KPI monitoring by Finance & Performance Committee and clinical audits by the Clinical Audit and Effectiveness Committee and Quality & Safety Committee.

In line with NHS England guidance on the Quality Account reporting for 2017/18 and the Quality Account toolkit 2010/11 the draft Quality Account will receive local external scrutiny from:

- Dudley CCG
- Walsall CCG
- Dudley Healthwatch
- Walsall Healthwatch
- Dudley Health and Well Being Board
- Walsall Health and Well Being Board

4.6.1 *Review of effectiveness*

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The Head of Internal Audit provided 'significant assurance', within his Head of Internal Audit Opinion for 2019 / 20, that:

- There is there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently
- An Assurance Framework has been established which is designed and operating to meet the requirements of the 2019 / 20 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation
- Taking account of the respective levels of assurance provided for each audit review, an assessment of the relevant weighting of each individual assignment and the extent to which agreed actions have been implemented, that the Trust has a generally sound system of internal control

Executive Managers within the Trust who are responsible for the development and maintenance of the system of internal control provide assurance in relation to the same.

The Board Assurance Framework provides evidence that the adequacy and effectiveness of controls that manage the principal risks to the organisation achieving its principal objectives are being reviewed. Furthermore the Internal Audit opinion is that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2019 / 20 Annual Governance Statement and provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The internal audit programme, the clinical audit programme, CQC registration, the performance framework, the Quality Governance Framework and the CQC Chief Inspector of Hospitals inspection provide further assurance on the effectiveness of the internal control systems.

The Audit Committee continues to manage the programme of internal audit, whilst the Quality and Safety Committee has reviewed and approved clinical audit plans, monitored progress and outcomes and have provided confirmation to Audit Committee that there are appropriate levels of assurance in place to enable Audit Committee to approve the draft Annual Governance Statement. Compliance with the CQC Registration requirements is monitored through the Trust's CQC Steering Group.

I take further assurance from the Quality and Safety Committee which has continued to receive feedback from the Trust's Experts by Experience and from the Board which has heard their reflections on a quarterly basis through the year. The Board has also continued during the year to receive patient stories on a quarterly basis, this practice has been expanded to also receive staff stories. This triangulation has been supplemented during the year through a protocol to embed the Board Visibility Programme 'On Board' in the quality improvement process.

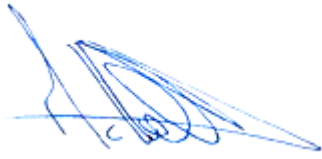
4.6.2 *Head of Internal Opinion*

Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

4.6.3 *Conclusion*

Each director: knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Having considered the contents of the annual governance statement, I conclude that there have been no significant internal control issues that have been identified.



Signed

Mark Axcell Chief Executive

Date: 24 June 2020



Signed

Paul Assinder Chief Executive

Date: 24 June 2020

5 REMUNERATION AND STAFF REPORT

5.1 Remuneration Policy

5.1.1 *Directors' Remuneration and Terms and Conditions*

The remuneration and terms and conditions for Directors who sit on the Board (except Non-Executive Directors) are set by the Nominations and Remuneration Committee. Remuneration for Executive Directors (excluding the Joint Medical Directors) has been set using benchmark information for similar Very Senior Manager Pay. The Joint Medical Directors pay is in line with the Medical Consultant Contracts and an element of their pay reflects their Board/management responsibilities.

All Executive Directors receive regular appraisal. The Non-Executive Directors are appraised by the Chair of the Trust, as is the Chief Executive. The other Executive Directors are appraised by the Chief Executive. The Nominations and Remuneration Committee have not determined any performance related pay arrangements or bonuses. Any inflationary pay award for the Chief Executive is determined annually by the Nominations and Remuneration Committee.

All Directors are on substantive contracts of employment are subject to a six month notice period including the Chief Executive. Any termination payment would be determined in line with the standard NHS redundancy payment scheme, where appropriate. No termination payments have been made during the reporting period.

The purpose of the Nominations and Remuneration Committee is to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors and to regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.

The Nominations and Remuneration Committee has no authority to determine remuneration arrangements for Non-Executive Directors for whom nationally determined terms will apply.

The Nominations and Remuneration Committee was chaired by Harry Turner and members are the Chair and all the Non-Executive and Associate Non-Executive Directors. In addition, when appointing executive directors other than the Chief Executive, the Chief Executive will attend the Committee.

5.1.2 Remuneration Report Tables

Figure 53 Single Total Figure Table – 2019/20

Name Title <i>Period of Office</i> <i>(if not 01/04/2019 – 31/03/2020)</i>	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) total (to nearest £100) £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Harry Turner Chair <i>01/04/2019 – 30/06/2019</i>	5 – 10	9	-	-	-	5 – 10
Simon Murphy Chair <i>01/07/2019 – 30/09/2019</i> Non-Executive Director <i>01/04/2019 – 30/06/2019 and</i> <i>01/10/2019 – 31/03/2020</i>	5-10	10	-	-	-	10 – 15
Mark Axcell Chief Executive	140 – 150	10	-	-	7.5 – 10.0	155 – 160
Robert Pickup Interim Director of Finance <i>01/11/2019 – 31/03/2020</i>	35 – 40	-	-	-	495.0 – 497.5	530 – 535
Marsha Foster Acting Director of Operations	100 – 105	-	-	-	7.5 – 10.0	110 – 115
Rosie Musson Acting Director of Nursing	100 – 105	-	-	-	-	50 – 55
Ashi Williams Acting Director of People	85 – 90	8	-	-	15.0 – 17.5	105 – 110
Dr Mark Weaver Medical Director	200 – 205	39	-	-	20.0 – 22.5	225 – 230

John Lancaster Non-Executive Director	5 – 10	18	-	-	-	5 – 10
Chris Fearnese Non-Executive Director	5 – 10	13	-	-	-	5 – 10
Debbie Nixon Non-Executive Director	5 – 10	10	-	-	-	5 – 10
Adam Williams Non-Executive Director	5 – 10	6	-	-	-	5 – 10
Tracey Orr Non-Executive Director <i>01/04/2019 – 30/11/2019</i>	0 – 5	-	-	-	-	0 – 5

Medical Directors remuneration in relation to clinical role was as follows:

- Dr Mark Weaver £150,000 - £155,000

Between 1 September 2018 and 31 October 2019, the services of Robert Pickup as Interim Director of Finance, Performance and IM&T were provided under an agreement with Birmingham and Solihull Mental Health NHS Foundation Trust. The benefit paid to Birmingham and Solihull Mental Health Partnership NHS Trust from 1 April 2019 and 31 October 2019 in respect of these services was £73,000.

From 1 December 2019 Robert Pickup is a first time entry to the Greenbury requirements and, therefore, previous year figures are not available. As such the all pension-related benefits reported in year are inflated and do not represent true figures for this financial year.

Senior staff members that regularly attend the Board and are non-voting include the following:

- Paul Lewis-Grundy, Company Secretary

Figure 54 Single Total Figure Table – 2018/19

Name Title <i>Period of Office</i> <i>(if not 01/04/2018 – 31/03/2019)</i>	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) total (to nearest £100) £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Harry Turner Chair	30.0 – 35.0	27	-	-	-	30.0 – 35.0
Mark Axcell Chief Executive	145.0 – 150.0	14	-	-	22.5 – 25.0	170.0 – 175.0
Rupert Davies Director of Finance, Performance and IM&T <i>01/04/2018 – 31/08/2018</i>	40.0 – 45.0	0	-	-	-	40.0 – 45.0
Wendy Pugh Director of Nursing, Operations and Estates <i>01/04/2018 – 19/04/2018</i>	0.0 – 5.0	0	-	-	0.0 – 2.5	5.0 – 10.0
Marsha Foster Acting Director of Operations	100.0 – 105.0	0	-	-	62.5 – 65.0	165.0 – 170.0
Rosie Musson Acting Director of Nursing	100.0 – 105.0	0	-	-	135.0 – 137.5	235.0 – 240.0
Ashi Williams Acting Director of People	85.0 – 90.0	10	-	-	37.5 – 40.0	130.0 – 135.0
Dr Mark Weaver Medical Director	195.0 – 200.0	6	-	-	22.5 – 25.0	220.0 – 225.0
Dr Iftikhar Ahmad Medical Director <i>14/05/2018 – 08/02/2019</i>	110.0 – 115.0	1	-	-	135.0 – 137.5	250.0 – 255.0
Simon Murphy Non-Executive Director	5.0 – 10.0	17	-	-	-	5.0 – 10.0
Pawiter Rana Non-Executive Director <i>01/04/2018 – 30/09/2018</i>	0.0 – 5.0	0	-	-	-	0.0 – 5.0

John Lancaster Non-Executive Director	5.0 – 10.0	23	-	-	-	5.0 – 10.0
Chris Fearnese Non-Executive Director	5.0 – 10.0	10	-	-	-	5.0 – 10.0
Debbie Nixon Non-Executive Director	5.0 – 10.0	9	-	-	-	5.0 – 10.0
Adam Williams Non-Executive Director	5.0 – 10.0	2	-	-	-	5.0 – 10.0
Tracey Orr Non-Executive Director	5.0 – 10.0	0	-	-	-	5.0 – 10.0

Medical Directors remuneration in relation to their clinical roles was as follows:

- Dr Mark Weaver £135,000 - £140,000
- Dr Iftikhar Ahmed £45,000 - £50,000

Since 1 September 2018, the services of Robert Pickup as Interim Director of Finance, Performance and IM&T have been provided under an agreement with Birmingham and Solihull Mental Health NHS Foundation Trust.

Robert Pickup was not directly remunerated by Dudley and Walsall Mental Health Partnership NHS Trust for services performed as the Interim Director of Finance, Performance and IM&T. The benefit paid to Birmingham and Solihull Mental Health Partnership NHS Trust in respect of these services was £72,000.

Senior staff members that regularly attend the Board and are non-voting include the following:

- Paul Lewis-Grundy, Company Secretary

Figure 55 Pension Benefits – 2019/20

Name Title <i>Period of Office</i> <i>(if not 01/04/2019 – 31/03/2020)</i>	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2019 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2020 £000	(h) Employer's contribution to stakeholder pension £000
Mark Axcell Chief Executive	0.0 – 2.5	-	50.0 – 55.0	120.0 – 125.0	850	32	902	-
Robert Pickup Interim Director of Finance, Performance and IM&T <i>01/11/2019 – 31/03/2020</i>	22.5 – 25.0	42.5 – 45.0	20.0 – 25.0	40.0 – 45.0	-	314	314	-
Marsha Foster Acting Director of Operations	0.0 – 2.5	-	30.0 – 35.0	70.0 – 75.0	538	21	572	-
Rosie Musson Acting Director of Nursing	-	-	45.0 – 50.0	145.0 – 150.0	1,003	-	1,017	-
Ashi Williams Acting Director of People	0.0 – 2.5	-	15.0 – 20.0	30.0 – 35.0	226	18	249	-
Dr Mark Weaver Medical Director	0.0 – 2.5	5.0 – 7.5	100.0 – 105.0	305.0 – 310.0	2,307	111	2,473	-

Between 1 September 2018 and 31 October 2019, the services of Robert Pickup as Interim Director of Finance, Performance and IM&T were provided under an agreement with Birmingham and Solihull Mental Health NHS Foundation Trust. The benefit paid to Birmingham and Solihull Mental Health Partnership NHS Trust from 1 April 2019 and 31 October 2019 in respect of these services was £73,000.

From 1 December 2019 Robert Pickup is a first time entry to the Greenbury requirements and, therefore, previous year figures are not available. As such the real increases reported in year are inflated and do not represent true growth figures for this financial year.

Senior staff members that regularly attend the Board and are non-voting include the following:

- Paul Lewis-Grundy, Company Secretary

5.1.3 *CETV disclosures for each director (Subject to audit)*

Cash Equivalent Transfer Values Disclosures for Directors – subject to audit

As Non-Executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive directors.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Treatment of Pension Liabilities in the Accounts

The policy on accounting for pensions can be found at note 9 to the Annual Accounts, and details of the pension schemes to which Dudley and Walsall Mental Health Partnership NHS Trust has contributed, together with the amount of employer contributions, are detailed in note 8 to the Annual Accounts.

Details of Directors' pension entitlements are contained in the Remuneration Report.

Compensation for loss of office (subject to audit)

The Trust made no compensation for loss of office during 2019/20.

Payments to past directors (subject to audit)

The Trust made no payments to past directors during 2019/20.

5.1.4 *Pay Multiples (Subject to audit)*

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2019/20 was £202,500 (2018/19 £197,500). This was 6.4 times (2018/19, 6.7 times) the median remuneration of the workforce, which was £31,821 (2018/19 £29,608).

The small decrease in the ratio between 2018/19 and 2019/20 was due to the increase in the median remuneration of the workforce of £2,213 (7.5%). This reflects the pay increases and one-off payments received in year 2 (2019/20) of the three year deal agreed by the NHS Staff Council in 2018.

In 2019 / 20 one employee received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

5.2 Staff Report (Subject to audit)

Our workforce is typical of most NHS provider organisations with female staff making up the majority of employees, in our case 76.7% of our workforce. 32.89% of colleagues have worked in our organisation for more than 10 years and only 15.86% of the workforce has less than 12 months service.

5.2.1 Number of senior civil service staff (or senior managers) by band

Figure 56 Number of senior civil service staff (or senior managers) by band

Band	Headcount No.
Senior Manager	5
Consultant	1
Total	6

5.2.2 Staff Numbers and Costs – subject to audit

Figure 57 Analysis of staff numbers – average number of employees on a whole time equivalent (WTE) basis

Average Staff Numbers	2019/20			2018/19
	Permanent No.	Other No.	Total No.	Total No.
Medical and dental	74	15	89	83
Administration and estates	351	25	376	306
Healthcare assistants and other support staff	260	88	348	242
Nursing, midwifery and health visiting staff	453	37	490	455
Scientific, therapeutic and technical staff	170	9	179	170
Other	13	0	13	26
Total average numbers	1,321	174	1,495	1,282
Of which:				
No. of employees engaged on capital projects	2	18	20	5

Figure 58 Staff Costs

Staff Costs	2019/20			2018/19
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	43,977	3,411	47,388	41,874
Social security costs	4,147	281	4,428	4,026
Apprenticeship levy	215	-	215	189
Employer's contributions to NHS pensions	8,269	-	8,269	5,150
Pension cost – other	16	-	16	9
Termination benefits	81	-	81	-
Temporary staff	-	5,628	5,628	4,870
Total gross staff costs	56,705	7,797	66,025	56,118
Of which:				
Costs capitalised as part of assets	152	1,986	2,138	497

Staff Composition – subject to audit

Figure 59 Staff composition by gender

Gender	Headcount No.	Headcount %
Female	1040	76.7
Male	316	23.3
Total	1,356	100.0

Figure 60 Staff composition by grade

Grade	Female Headcount No.	Male Headcount No.	Total Headcount No.
Director	3	3	6
Employee	1037	313	1350
Total	1040	316	1356

5.2.3 Sickness absence data

Figure 61 Sickness Absence Data

	2019/20 No.	2018/19 No.
Total Days Lost FTE	19,921	16,816
Avg FTE of Staff	1,171	1,057
Average Absence Days Lost per FTE	17.0	15.9

Staff policies

5.2.4 Supporting staff with disabilities

We are committed to supporting staff that have a disability or become disabled during the demonstrating that we meet the standard to encourage and make adjustments for applicants with disabilities, and to guarantee an interview to those who meet the person specification for the post. We actively work with staff who become disabled to seek and make reasonable adjustments which will enable them to continue at work. We also actively support staff with both physical and mental health needs and have a robust Occupational Health and Staff Support service. The Trust holds the Positive about Disability Two Ticks kite mark.

The Trust has established a Disability Network which has developed priorities to address in order to improve working conditions and experience of current and future employees.

The Trust is signed up to the Mindful Employer charter. The Charter for Employers who are Positive About Mental Health is a tangible display of commitment to improving the working lives of staff. It is different to the 'two ticks' Disability Symbol and other accreditations and is a Charter for Employers who are Positive About Mental Health.

All Policies are equality Impact assessed to ensure that there is no adverse impact on staff who may have a disability or if a disability should arise.

Modern Slavery Statement 2019/20

This statement, made pursuant to section 54(1) of the Modern Slavery Act 2015, sets out the approach taken by the Trust to understand all potential modern slavery risks related to its business, and the actions undertaken to mitigate any such risks during the financial year ended 31st March 2020.

The Trust is committed to delivering high standards of corporate governance and a key element of this is managing the Trust in a socially responsible way. The Trust is absolutely committed to preventing slavery and human trafficking in its corporate activities and its supply chains. The Trust also expects the same high standards which we set for ourselves from those parties with whom we engage, such as our suppliers and customers.

Due to the nature of our business and our approach to governance, we assess that there is very low risk of slavery and human trafficking in our business and supply chains. However, we aim to periodically review the effectiveness of the relevant policies and procedures that we have in place. We do not have key performance indicators in relation to slavery or human trafficking as any instance would be expected to be a breach of law, our supplier standards and/or our company policies.

5.2.5 Positive about Mental Health - Mindful Employer Charter

The Trust is a signatory of the Mindful Employers Charter. As a Trust we recognise that:

- People who have mental health issues may have experienced discrimination in recruitment and selection procedure. This may discourage them from seeking employment
- Whilst some people will acknowledge their experience of mental health issues in a frank and open way, others fear that stigma will jeopardise their chances of getting a job
- Given appropriate support, the vast majority of people who have experienced mental ill health continue to work successfully as do many with on-going issues

As an employer we:

- Show a positive and enabling attitude to employees and job applicants with mental health issues. This will include positive statements in local recruitment literature
- Ensure that all staff involved in recruitment and selection are briefed on mental health issues and the Equality Act 2010, and given appropriate interview skills
- Make it clear in any recruitment or occupational health check that people who have experienced mental health issues will not be discriminated against and that disclosure of a mental health problem will
- enable both employee and employer to assess and provide the right level of support or adjustment
- Do not make assumptions that a person with a mental health issue will be more vulnerable to workplace stress or take more time off than any other employee or job applicant
- Provide non-judgemental and proactive support to individual staff who experience mental health issues
- Ensure all line managers have information and training about managing mental health in the workplace

5.2.6 Trade Union Facility Time Reporting Requirements

SCHEDULE 2 Information to be published 2019/20

Figure 62 Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?

<i>Number of employees who were relevant union officials during the relevant period</i>	<i>Full-time equivalent employee number</i>
7	6.62WTE

Figure 63 Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	
1-50%	6
51%-99%	1
100%	

Figure 64 Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	Figures
Provide the total cost of facility time	£30,312
Provide the total pay bill	£63,887k
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.047%

Figure 65 Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0.514%
--	--------

5.3 Expenditure on Consultancy

Expenditure on consultancy in 2019/20 was £338,000 (2018/19: £802,000).

5.4 Reporting related to the review of Tax Arrangement of Public Sector Appointee

Following the Review of the Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the treasury on 23 May 2012, departments and their arm's length bodies (this is taken to include all those bodies included within the DHSC reporting boundary) must publish information on their highly paid and/or senior off-payroll engagements.

5.5 Off-payroll engagements

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months.

Figure 66 Off-payroll engagements longer than 6 months

	Number of off-payroll engagements No.
No. of existing engagements as of 31 March 2020	4
Of which:	
No. that have existed for less than one year at time of reporting	0
No. that have existed between one and two years at time of reporting	1
No. that have existed between two and three years at time of reporting	3
No. that have existed between three and four years at time of reporting	0
No. that have existed between four years or more at time of reporting	0

For all new off-payroll engagements, or those that have reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months.

Figure 67 New Off-payroll Engagements

	Number of off-payroll engagements No.
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	16
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	16
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

Figure 68 Off-payroll board members/senior official engagements

	Number of off-payroll engagements
No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	-
No. of individuals that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year	7

5.6 Exit Packages

Figure 69 Reporting of compensation schemes – exit packages 2019/20

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agree	Total number of exit packages
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	1	-	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	1	-	1
Total resource cost (£)	81,000	-	81,000

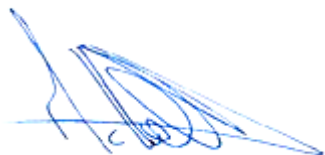
Figure 70 Reporting of compensation schemes – exit packages 2018/19

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost (£)	-	-	-

Figure 71 Exit packages: other (non-compulsory) departure payments

	2019/20		2018/19	
	Number of payments agreed	Total value of agreements £000	Number of Payments agreed	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignation (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

I confirm adherence to the reporting framework in preparation of the Accountability Report.



Signed

Mark Axcell Chief Executive

Date: 24 June 2020



Signed

Paul Assinder Chief Executive

Date: 24 June 2020

5.7 Independent auditor's report to the Directors of Dudley and Walsall Mental Health Partnership NHS Trust

Independent auditor's report to the Directors of Dudley and Walsall Mental Health Partnership NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Dudley and Walsall Mental Health Partnership NHS Trust (the 'Trust') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and Notes to the Accounts, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the Trust's financial statements shall be prepared on a going concern basis, we considered the risks associated with the Trust's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the Trust's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Emphasis of Matter – Transfer of Services

We draw attention to Note 1.17 to the financial statements, which describes the transfer of the majority of services provided by the Trust to a new entity, Black Country Healthcare NHS Foundation Trust, on 1 April 2020. The remaining services will remain with the Trust. Our opinion is not modified in respect of this matter.

Emphasis of Matter – effects of Covid-19 on the valuation of land and buildings

We draw attention to Note 1.16.1 to the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As disclosed in note 1.16.1 to the financial statements, the Trust's property assets were subject to a desktop valuation with an effective date of 31 March 2020. The Trust's valuation report included a 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty and a higher degree of caution should be attached to management's valuation of land buildings than would normally be the case. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

The Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, except for the effects of the matter described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, Dudley and Walsall Mental Health Partnership NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters surrounding the Electronic Patient Records (EPR) project (Rio system):

In 2018 the Trust started to develop its new Electronic Patient Record (EPR) system. This was a mixture of procured services and in-house development. This project was split into 2 distinct phases. Phase 1 (Children's, Young People and Families and Learning Disabilities) due for implementation in May 2019 and Phase 2 (Adults, Older Adults and Community Mental Health Services) due to go live in August 2019. No outline or full business case was prepared. There was considerable slippage of the planned delivery timescale and significant overspend against planned costs, which are now forecast to be £5.513 million. Project cost approval processes were not followed and the quality of financial reporting of the project was poor. Phase 1 of the project did not become operational until November 2019 and phase 2 timescale for implementation has been moved to October 2020.

These matters identify weaknesses in the Trusts arrangements relating to the planning, delivery, monitoring and governance of the EPR system. They are evidence of weaknesses in proper arrangements for informed decision making in understanding and using appropriate and reliable financial and performance information to support informed decision making and performance management including where relevant, business cases supporting significant investment decisions.

Responsibilities of the Accountable Officer

The Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Dudley and Walsall Mental Health Partnership NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark Stocks, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

24 June 2020

PART C Financial statements

Dudley and Walsall Mental Health Partnership
NHS Trust

Annual accounts for the year ended 31 March
2020

Statement of Comprehensive Income

		2019/20	2018/19
	Note	£000	£000
Operating income from patient care activities	3	76,353	67,054
Other operating income	4	5,633	7,286
Operating expenses	6.1	<u>(80,904)</u>	<u>(72,764)</u>
Operating surplus/(deficit) from continuing operations		<u>1,082</u>	<u>1,576</u>
Finance income	11	137	122
PDC dividends payable		<u>(817)</u>	<u>(743)</u>
Net finance costs		<u>(680)</u>	<u>(621)</u>
Other gains / (losses)	12	-	1
Surplus / (deficit) for the year		<u>402</u>	<u>956</u>
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(502)
Revaluations	15	-	-
Total comprehensive income / (expense) for the period		<u>402</u>	<u>454</u>
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		402	956
Remove net impairments not scoring to the Departmental expenditure limit		<u>1,227</u>	<u>2,094</u>
Adjusted financial performance surplus / (deficit)		<u>1,629</u>	<u>3,050</u>

Statement of Financial Position


		31 March 2020	31 March 2019
	Note	£000	£000
Non-current assets			
Intangible assets	13	3,569	1,248
Property, plant and equipment	14	28,851	28,175
Total non-current assets		32,420	29,423
Current assets			
Receivables	16	5,663	4,843
Cash and cash equivalents	17	14,574	18,818
Total current assets		20,237	23,661
Current liabilities			
Trade and other payables	18	(5,984)	(7,390)
Provisions	19	(1,121)	(691)
Total current liabilities		(7,105)	(8,081)
Total assets less current liabilities		45,552	45,003
Total assets employed		45,552	45,003
Financed by			
Public dividend capital		47,821	47,674
Revaluation reserve		255	255
Income and expenditure reserve		(2,524)	(2,926)
Total taxpayers' equity		45,552	45,003

The notes on pages AA5 to AA37 form part of these accounts.

Name



Paul Assinder



Mark Axcell

Position

Chief Executive

Date

24-Jun-20

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2019 - brought forward	47,674	255	(2,926)	45,003
Surplus/(deficit) for the year	-	-	402	402
Impairments	-	-	-	-
Public dividend capital received	147	-	-	147
Taxpayers' equity at 31 March 2020	47,821	255	(2,524)	45,552

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	47,536	757	(3,882)	44,411
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-
Surplus/(deficit) for the year	-	-	956	956
Revaluations	-	(502)	-	(502)
Public dividend capital received	138	-	-	138
Taxpayers' equity at 31 March 2019	47,674	255	(2,926)	45,003

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income.

Subsequent downward movements in asset valuations are charged to the revaluation reserve, to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

		2019/20	2018/19
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		1,082	1,576
Non-cash income and expense:			
Depreciation and amortisation	6.1	1,903	1,796
Net impairments	7	1,227	2,098
(Increase) / decrease in receivables and other assets		(925)	(226)
Increase / (decrease) in payables and other liabilities		(1,266)	(456)
Increase / (decrease) in provisions		430	80
Net cash generated from / (used in) operating activities		<u>2,451</u>	<u>4,868</u>
Cash flows from investing activities			
Interest received		140	117
Purchase of intangible assets		(2,845)	(1,011)
Purchase of property, plant, equipment and investment property		(3,422)	(2,447)
Net cash generated from / (used in) investing activities		<u>(6,127)</u>	<u>(3,341)</u>
Cash flows from financing activities			
Public dividend capital received		147	138
PDC dividend (paid) / refunded		(715)	(829)
Net cash generated from / (used in) financing activities		<u>(568)</u>	<u>(691)</u>
Increase / (decrease) in cash and cash equivalents		<u>(4,244)</u>	<u>836</u>
Cash and cash equivalents at 1 April - brought forward		<u>18,818</u>	<u>17,982</u>
Cash and cash equivalents at 31 March	17.1	<u>14,574</u>	<u>18,818</u>

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

As part of the financial statements preparation process, and as required under IAS 1, the Trust's Board of Directors have assessed the Trust's ability to continue as a going concern.

Merger of Dudley and Walsall Mental Health Partnership NHS Trust and Black Country Partnership NHS Foundation Trust

As part of the financial statements preparation process, and as required under IAS 1, the Trust's Board of Directors have assessed the Trust's ability to continue as a going concern.

In November 2019, a strategic outline case was submitted to NHSI for the creation of the new Integrated Care Provider in Dudley following a procurement exercise where the Trust and partner NHS organisations within the system were successful in being identified as the preferred bidders for the ICP contract. The strategic outline case and subsequent addendum to the case was approved by NHSI which resulted in the Trust continuing to operate beyond the 1st April 2020 for the purposes of creating the new Integrated Care Provider organisation. The full business case for the award of the main ICP contract will be submitted in due course following the response to the Covid-19 crisis.

On 1 April 2020 the majority of services provided by Dudley and Walsall Mental Health Partnership NHS Trust and their associated non-current assets were transferred to Black Country Partnership NHS Foundation Trust. The resulting merged organisation is operating as Black Country Healthcare NHS Foundation Trust. Two services, Dudley Improving Access to Psychological Services (IAPT) and Dudley Primary Mental Health Care, remain within the Trust along with their associated non-current assets and all net current assets. As all services and assets remain within the National Health Service, allowing operational activity to continue uninterrupted, and all liabilities are still expected to be settled the Trust can be considered a going concern beyond the transaction date.

From the 1st April 2020, the Trust has taken on responsibility for the provision of the Pensnett Assessment Centre as part of the Covid-19 response. A proposal has also been approved at the CCG Procurement Board for a number of services to transfer to the Trust in advance of the main ICP contract award. Subject to appropriate due diligence these services are expected to transfer to the Trust on the 1st October 2020.

The final award of the main ICP contract is subject to the approval of the Final Business Case by NHSI and consultation with other providers. The transfer of services from the CCG is subject to the approval of the Governing Body of Dudley CCG. The Trust has reviewed the cashflow forecast based on the current level of service provision (prior to any further transfer of services) and is satisfied that there is sufficient cash available to meet the requirements of the organisation until the end of June 2021. As such the Board has determined that the Trust remains a going concern. Without the transfer of these services the Trust would require on-going financial support to continue to be a going concern beyond 30 June 2021.

There are no indicators that the Trust will not continue to trade beyond 30 June 2021.

Covid-19

The outbreak of Covid-19, declared by the World Health Organisation as a global pandemic on 11 March 2020, has impacted on global financial markets. For many commercial organisations, Covid-19 is a material uncertainty that will cast significant doubt over their ability to continue as a going concern. For NHS bodies, this is not the case. The Chancellor's statement in the Budget 2020 that 'whatever extra resources our NHS needs to cope with coronavirus – it will get' means that, for the period of crisis, there is more certainty about funding than ever before.

These accounts have been prepared on a going concern basis.

Note 1 Accounting policies and other information (continued)

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations, which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time, as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Education and Training

Education and Training income is income received for the delivery of education and training to medical, and other students, on placements within the Trust. Performance obligations relating to delivery of placements are generally satisfied over time, as training income is received by the Trust and training and education consumed by the customer simultaneously. The customer in such a contract is Health Education England, or the training commissioner, but the customer benefits as training and education is provided to their student.

Other Income

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Note 1.3.1 Grants and donations

Government grants are grants from government bodies, other than income from commissioners or Trusts, for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Note 1 Accounting policies and other information (continued)

Note 1.3.2 Apprenticeship service income

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme, except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has a cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1 Accounting policies and other information (continued)

Note 1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use, are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

All land and buildings are restated to fair value using professional valuations in accordance with IAS16 every five years. Three-year interim revaluations and annual desktop valuation exercises are also carried out. The last asset valuation was undertaken in 2019 with an effective valuation date of 31 March 2019.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

The property valuations are carried out primarily on the basis of (DRC) for specialised operational property (e.g. NHS patient treatment facilities) and Existing Use Value (EUV) for non-specialised operational property. The value of land for existing use purposes is assessed at EUV. For non-operational land, including surplus land, the valuations are carried out at Market Value.

The Department of Health has adopted the Modern Equivalent Asset (MEA) approach for its DRC valuations rather than the previous identical replacement method. The MEA approach used to value the property will normally be based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence. In the past, functional obsolescence has not been reflected in asset valuations for the NHS.

Note 1 Accounting policies and other information (continued)

Note 1.6 Property, plant and equipment (continued)

Note 1.6.2 Measurement (continued)

Valuation (continued)

Functional obsolescence examines a building's design or specification, and whether it may no longer fulfil the function for which it was originally designed, or whether it may be much more basic than the MEA. The asset will still be capable of use but at a lower level of efficiency than the MEA, or may be capable of modification to bring it up to a current specification. Other common causes of functional obsolescence include advances in technology or legislative change. The obsolescence adjustment will reflect either the cost of upgrading, or if this is not possible, the financial consequences of the reduced efficiency compared with the modern equivalent.

The MEA approach incorporates the Building Cost Information Service Index, to determine an increase or decrease in building costs which impact on the asset valuation.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

The costs arising from financing the construction of property, plant and equipment are not capitalised but are charged to the Statement of Comprehensive Income (SOCl) in the year to which they relate.

All impairments resulting from price changes are charged to the SOCl. If the balance on the revaluation reserve is less than the impairment the difference is taken to SOCl.

The Trust's land and building valuation was carried out by the Trust's current valuer District Valuer Services (DVS), the commercial arm of the government owned Valuation Office Agency on a MEA "Alternative Site" method valuation, and applied on 31 March 2019. This valuation takes into account that all services currently provided by the Trust could theoretically be provided from one of the Trust's existing hospital sites, namely Dorothy Pattison Hospital in Walsall.

The valuation has been undertaken having regard to IFRS as applied to the UK public sector and in accordance with HM Treasury guidance. The Trust has valued its land and buildings at fair value - non-specialised assets at existing use value and specialised operation assets at depreciated replacement cost.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1 Accounting policies and other information (continued)

Note 1.6 Property, plant and equipment (continued)

Note 1.6.2 Measurement (continued)

Valuation (continued)

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Note 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the sale must be highly probable and the asset available for immediate sale in its present condition

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**Note 1 Accounting policies and other information
(continued)**

Note 1.6 Property, plant and equipment (continued)

Note 1.6.4 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	-	30
Plant & machinery	-	10
Transport equipment	-	2
Information technology	-	5
Furniture & fittings	-	10

The gross carrying amount of fully depreciated property, plant and equipment assets still in use is £1,187,000 at 31 March 2020.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell

Note 1 Accounting policies and other information (continued)

Note 1.7 Intangible assets (continued)

Note 1.7.2 Measurement

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic life of intangible

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	-	10

The gross carrying amount of fully depreciated intangible assets still in use is £1,897,000 at 31 March 2020.

Note 1.8 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial assets and financial liabilities

Note 1.9.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations, which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie. when receipt or delivery of the goods or services is made.

Note 1.9.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value, plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Note 1 Accounting policies and other information (continued)

Note 1.9 Financial assets and financial liabilities (continued)

Note 1.9.2 Classification and measurement (continued)

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability, and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables and contract assets, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently, at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses are determined using an expected credit loss provision matrix. Lifetime expected loss rates have been calculated with reference to historical experience of losses incurred on Local Authority and other Non-NHS contract receivables, with separate loss rates established for each. Adjustments are made for any forward looking information available to the Trust at the point that the provision is made.

Credit losses are not normally recognised in relation to other NHS organisations.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.9.3 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired, or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.10.1 The Trust as lessee

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently, as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1 Accounting policies and other information (continued)

Note 1.11 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years and up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

		Inflation rate
Year 1		1.90%
Year 2		2.00%
Into perpetuity		2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 19.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes; under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.12 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for;

- (i) donated and grant funded assets,
- (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1 Accounting policies and other information (continued)

Note 1.13 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category, or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.14 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.15 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.16 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below), that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

The Trust has concluded that it operates and reports as a single segment - the provision of mental healthcare. The judgement has been reached through analysis of IFRS 8 by senior finance management and via a consultation process with similar organisations. The judgement does not impact on the primary statements, merely what is disclosed in the notes to the accounts.

Note 1.16.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty, that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The Trust's property assets (land and buildings) were subject to a desktop valuation with an effective date of 31 March 2020. The valuation was undertaken on a Modern Equivalent Asset (MEA) alternative site basis. As in previous years, this assumed that the physical assets would be replaced with a modern equivalent asset capable of delivering the same service potential but not of an identical design. As a result the MEA asset is smaller, having a reduced Gross Internal Area (GIA) and resulting valuation. Future valuations of these assets and any changes to the basis of valuation may result in material changes to the carrying values of non-current assets.

The outbreak of Covid-19 is a further source of estimation uncertainty for the Trust and the NHS as a whole. It has impacted on global financial markets. The duration of the impact of Covid-19 is unclear and the likely short, medium to long term effects are hard to predict.

The impact of Covid-19 on Valuation

In respect to the Global response to Novel Coronavirus (COVID-19) the Trust's valuers were faced with an unprecedented set of circumstances on which to base a judgement. Therefore, they have reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to the valuation of Land and Buildings than would normally be the case.

For example, a 5% change in the valuation would have £1,333,000 impact on the statement of financial position with a £47,000 impact on the PDC dividend due to be paid next year and accrued in these financial statements.

Of the £26,659,000 net book value of land and buildings subject to valuation, £24,346,000 relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

Note 1 Accounting policies and other information (continued)

Note 1.16.2 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1 Accounting policies and other information (continued)

Note 1.16.3 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

The DHSC GAM does not require the following standard and interpretation to be applied in 2019/20. This standard is still subject to HM Treasury FReM adoption.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

The Trust is unable to provide a full assessment of the impact of the adoption of this standard at this time, however, it is expected that the impact will not be significant.

Note 1 Accounting policies and other information (continued)

Note 1.17 Transfer of Services

On 1 April 2020 the majority of services provided by Dudley and Walsall Mental Health Partnership NHS Trust and their associated non-current assets were transferred to Black Country Partnership NHS Foundation Trust. The resulting merged organisation is operating as Black Country Healthcare NHS Foundation Trust. Two services, Dudley Improving Access to Psychological Services (IAPT) and Dudley Primary Mental Health Care, remain within the Trust along with their associated non-current assets and all net current assets. As all services and assets remain within the National Health Service, allowing operational activity to continue uninterrupted, and all liabilities are still expected to be settled the Trust can be considered a going concern beyond the transaction date.

The transfer will not be fully transacted and Public Dividend Capital (PDC) transferred until the Secretary of State has determined the values of PDC to be transferred. Based on these accounts, the Statement of Financial Position for the Trust following the transfer is expected to be impacted as follows:

Expected Statement of Financial Position at 1 April 2020

	£000
Non-current assets	
Intangible assets	-
Property, plant and equipment	50
Total non-current assets	50
Current assets	
Receivables	5,663
Cash and cash equivalents	4,842
Total current assets	10,505
Current liabilities	
Trade and other payables	(5,984)
Loan	(567)
Provisions	(1,121)
Total current liabilities	(7,672)
Total assets less current liabilities	2,883
Non-current liabilities	
Loan	(2,833)
Total non-current liabilities	(2,833)
Total assets employed	50
Financed by	
Public dividend capital	50
Revaluation reserve	-
Income and expenditure reserve	-
Total taxpayers' equity	50

Note 2 Operating segments

The Trust operates as a single operating segment, the provision of Healthcare.

As a single segment the Trust receives £70,379,000 (2018/19: £63,666,000) of its income from CCGs. This equates to 86% (2018/19: 86%) of the Trust's total income of £81,986,000 (2018/19: £74,340,000).

The Trust receives in excess of 10% of its income from two single organisations, Dudley CCG £31,879,000 (2018/19: £29,219,000) and Walsall CCG £31,661,000 (2018/19: £28,567,000).

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)	2019/20	2018/19
	£000	£000
Mental health services		
Block contract income	71,363	64,312
Clinical partnerships providing mandatory services (including S75 agreements)	946	1,241
Clinical income for the secondary commissioning of mandatory services	-	178
Other clinical income from mandatory services	1,395	662
All services		
Agenda for Change pay award central funding*	-	657
Additional pension contribution central funding**	2,502	-
Other clinical income	147	4
Total income from activities	76,353	67,054

* Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20	2018/19
	£000	£000
NHS England	5,137	1,537
Clinical commissioning groups	70,261	63,426
Department of Health and Social Care	-	668
Other NHS providers	-	178
Local authorities	946	1,241
Non NHS: other	9	4
Total income from activities	76,353	67,054
Of which:		
Related to continuing operations	76,353	67,054

Note 4 Other operating income

	2019/20	2018/19
	£000	£000
Other operating income from contracts with customers:		
Education and training (excluding notional apprenticeship levy income)	2,791	2,004
Non-patient care services to other bodies	1,286	1,965
Provider sustainability / sustainability and transformation fund income (PSF / STF)	700	2,344
Income in respect of employee benefits accounted on a gross basis	419	631
Other contract income	323	234
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	96	102
Charitable and other contributions to expenditure	18	6
Total other operating income	<u>5,633</u>	<u>7,286</u>
Of which:		
Related to continuing operations	5,633	7,286

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2019/20
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.1 Transaction price allocated to remaining performance obligations

	31 March
	2020
	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	<u>-</u>

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed. Having reviewed the Trust's income streams, no additional disclosure is being made in respect of revenue from contracts with customers recognised in the period as all contracts either have a contract term covering 1 April 2019 to 31 March 2020 or are considered as falling into either (i) or (ii) above.

Note 6.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	347	346
Purchase of healthcare from non-NHS and non-DHSC bodies	115	212
Staff and executive directors costs	63,887	55,621
Remuneration of non-executive directors	60	76
Supplies and services - clinical (excluding drugs costs)	170	187
Supplies and services - general	799	661
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,772	1,630
Consultancy costs	338	802
Establishment	759	828
Premises	4,324	4,487
Transport (including patient travel)	521	593
Depreciation on property, plant and equipment	1,333	1,367
Amortisation on intangible assets	570	429
Net impairments	1,227	2,098
Movement in credit loss allowance: contract receivables / contract assets	4	5
Movement in credit loss allowance: all other receivables and investments	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	59	50
other auditor remuneration (external auditor only)	12	12
Internal audit costs	26	50
Clinical negligence	242	207
Legal fees	135	56
Insurance	3	3
Education and training	823	508
Rentals under operating leases	246	253
Other services, eg external payroll	3,132	2,095
Other	-	188
Total	<u>80,904</u>	<u>72,764</u>
Of which:		
Related to continuing operations	80,904	72,764

Note 6.2 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	12	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	12	12

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000,000 (2018/19: £2,000,000).

Note 7 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	4
Changes in market price	1,227	2,094
Total net impairments charged to operating surplus / deficit	1,227	2,098
Impairments charged to the revaluation reserve	-	502
Total net impairments	1,227	2,600

Note 8 Employee benefits

	2019/20	2018/19
	Total	Total
	£000	£000
Salaries and wages	47,388	41,874
Social security costs	4,428	4,026
Apprenticeship levy	215	189
Employer's contributions to NHS pensions	8,269	5,150
Pension cost - other	16	9
Termination benefits	81	-
Temporary staff (including agency)	5,628	4,870
Total gross staff costs	66,025	56,118
Recoveries in respect of seconded staff	-	-
Total staff costs	66,025	56,118
Of which		
Costs capitalised as part of assets	2,138	497

Note 8.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £17,000 (£99,000 in 2018/19).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Note 9.1 NHS pension scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 9.2 NEST pension scheme

As of 1 April 2013 it became a statutory requirement to enroll all eligible staff into a workplace pension scheme. Where employees are not eligible to enroll in the NHS Pension Scheme they are enrolled in the NEST Pension Scheme as an alternative. The employee can choose to "opt out" of the scheme after they have been auto-enrolled, this opt out lasts for three years, after which time the Trust will be required to re-enroll the employee. The Trust is required to make employer contributions of 2% of the employee's qualifying salary to the NEST Pension Scheme. For the period 1 April 2019 to 31 March 2020 the Trust has contributed £16,000.

Note 10 Operating leases**Note 10.1 Dudley and Walsall Mental Health Partnership NHS Trust as a lessee**

This note discloses costs and commitments incurred in operating lease arrangements where Dudley and Walsall Mental Health Partnership NHS Trust is the lessee.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	246	253
Total	<u>246</u>	<u>253</u>
	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	213	223
- later than one year and not later than five years;	455	554
- later than five years.	122	170
Total	<u>790</u>	<u>947</u>

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	137	122
Total finance income	<u>137</u>	<u>122</u>

Note 12 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	1
Total gains / (losses) on disposal of assets	<u>-</u>	<u>1</u>
Total other gains / (losses)	<u>-</u>	<u>1</u>

Note 13 Intangible assets

Note 13.1 Intangible assets - 2019/20

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	2,948	612	3,560
Additions	1,837	1,054	2,891
Reclassifications	1,666	(1,666)	-
Disposals	(685)	-	(685)
Valuation / gross cost at 31 March 2020	<u>5,766</u>	<u>-</u>	<u>5,766</u>
Amortisation at 1 April 2019 - brought forward	2,312	-	2,312
Provided during the year	570	-	570
Disposals	(685)	-	(685)
Amortisation at 31 March 2020	<u>2,197</u>	<u>-</u>	<u>2,197</u>
Net book value at 31 March 2020	3,569	-	3,569
Net book value at 1 April 2019	636	612	1,248

Note 13.2 Intangible assets - 2018/19

	Software licences	Intangible Assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	2,522	-	2,522
Additions	426	612	1,038
Valuation / gross cost at 31 March 2019	<u>2,948</u>	<u>612</u>	<u>3,560</u>
Amortisation at 1 April 2018 - as previously stated	1,883	-	1,883
Provided during the year	429	-	429
Amortisation at 31 March 2019	<u>2,312</u>	<u>-</u>	<u>2,312</u>
Net book value at 31 March 2019	636	612	1,248
Net book value at 1 April 2018	639	-	639

Note 14 Property, plant and equipment

Note 14.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under Construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	3,852	22,939	-	1,157	27	2,427	632	31,034
Additions	150	1,799	912	110	-	196	69	3,236
Impairments	-	-	-	-	-	-	-	-
Revaluations	-	(2,071)	-	-	-	-	-	(2,071)
Disposals	-	-	-	(150)	-	(230)	(106)	(486)
Valuation/gross cost at 31 March 2020	4,002	22,667	912	1,117	27	2,393	595	31,713
Accumulated depreciation at 1 April 2019 - brought forward	-	11	-	603	20	1,814	411	2,859
Provided during the year	-	843	-	133	2	283	72	1,333
Impairments	-	1,227	-	-	-	-	-	1,227
Revaluations	-	(2,071)	-	-	-	-	-	(2,071)
Disposals	-	-	-	(150)	-	(230)	(106)	(486)
Accumulated depreciation at 31 March 2020	-	10	-	586	22	1,867	377	2,862
Net book value at 31 March 2020	4,002	22,657	912	531	5	526	218	28,851
Net book value at 1 April 2019	3,852	22,928	-	554	7	613	221	28,175

Note 14.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under Construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	3,852	25,585	-	980	48	2,230	587	33,282
Additions	-	1,853	-	214	-	197	49	2,313
Impairments	-	(502)	-	-	-	-	-	(502)
Revaluations	-	(3,997)	-	-	-	-	-	(3,997)
Disposals	-	-	-	(37)	(21)	-	(4)	(62)
Valuation/gross cost at 31 March 2019	3,852	22,939	-	1,157	27	2,427	632	31,034
Accumulated depreciation at 1 April 2018 - as previously stated	-	989	-	529	39	1,548	348	3,453
Provided during the year	-	923	-	109	2	266	67	1,367
Impairments	-	2,096	-	2	-	-	-	2,098
Revaluations	-	(3,997)	-	-	-	-	-	(3,997)
Disposals	-	-	-	(37)	(21)	-	(4)	(62)
Accumulated depreciation at 31 March 2019	-	11	-	603	20	1,814	411	2,859
Net book value at 31 March 2019	3,852	22,928	-	554	7	613	221	28,175
Net book value at 1 April 2018	3,852	24,596	-	451	9	682	239	29,829

Note 14.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under Construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	4,002	22,657	912	531	5	526	218	28,851
NBV total at 31 March 2020	4,002	22,657	912	531	5	526	218	28,851

Note 14.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under Construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	3,852	22,928	-	554	7	613	221	28,175
NBV total at 31 March 2019	3,852	22,928	-	554	7	613	221	28,175

Note 15 Revaluations of property, plant and equipment

The Trust's property assets (land and buildings) are held at revalued amounts in the accounts.

The most recent valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. This was a desktop valuation and was undertaken by Jonathan Jones BSc (Hons) MRICS, Senior Surveyor, District Valuation Service (DVS). DVS is the commercial arm of the government-owned Valuation Office Agency.

The valuation was undertaken on a Modern Equivalent Asset (MEA) alternative site basis. As in previous years, this assumed that the numerous physical assets of the Trust would be replaced with modern equivalent asset capable of delivering the same service potential but not of an identical design and from a single location. As a result the MEA asset is smaller, having a reduced Gross Internal Area (GIA) and resulting valuation.

The valuation resulted in an overall reduction in the residual values of the Trust's non-current assets of £1,227,000. This was transacted as an impairment charged to I&E.

The impact of Covid-19 on Valuation

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

For example, a 5% change in the valuation would have £1,333,000 impact on the statement of financial position with a £47,000 impact on the PDC dividend due to be paid next year and accrued in these financial statements.

Of the £26,659,000 net book value of land and buildings subject to valuation, £24,346,000 relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

Note 16.1 Receivables

	31 March 2020	31 March 2019
	£000	£000
Current		
Contract receivables	4,796	4,062
Contract assets	-	-
Allowance for impaired contract receivables / assets	(10)	(6)
Prepayments (non-PFI)	398	473
Interest receivable	9	12
PDC dividend receivable	-	102
VAT receivable	126	167
Other receivables	344	33
Total current trade and other receivables	<u>5,663</u>	<u>4,843</u>
Of which receivables from NHS and DHSC group bodies:		
Current	4,472	3,886

Note 16.2 Allowances for credit losses - 2019/20

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2019 - brought forward	6	-
New allowances arising	4	-
Allowances as at 31 Mar 2020	<u>10</u>	<u>-</u>

Note 16.3 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - as previously stated	-	1
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1	(1)
New allowances arising	5	-
Allowances as at 31 Mar 2019	<u>6</u>	<u>-</u>

Note 16.4 Exposure to credit risk

The Trust's exposure to credit risk is quantified below.

Credit Loss Provision - Local Authority Contract Receivables

	Gross Amount	Lifetime Expected Loss Rate	Lifetime Expected Loss Allowance
	£000	%	£000
Days past due date			
Current	74	1.19	1
1-30 Days	37	0.84	0
31-60 Days	37	0.01	0
61-90 Days	37	0.51	0
Over 90 Days	287	2.84	9
Total	472		10

Credit Loss Provision - Other Non-NHS Contract Receivables

	Gross Amount	Lifetime Expected Loss Rate	Lifetime Expected Loss Allowance
	£000	%	£000
Days past due date			
Current	1	2.68	0
1-30 Days	1	3.23	0
31-60 Days	0	0.08	0
61-90 Days	0	0.15	0
Over 90 Days	36	0.79	0
Total	38		0

Note 17.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20	2018/19
	£000	£000
At 1 April	18,818	17,982
Net change in year	(4,244)	836
At 31 March	14,574	18,818
Broken down into:		
Cash at commercial banks and in hand	4	4
Cash with the Government Banking Service	14,570	18,814
Total cash and cash equivalents as in SoFP	14,574	18,818
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	14,574	18,818

Note 17.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	23	24
Total third party assets	23	24

Note 18 Trade and other payables

	31 March 2020	31 March 2019
	£000	£000
Current		
Trade payables	1,449	2,604
Capital payables	552	692
Accruals	1,518	1,746
Social security costs	748	644
VAT payables	2	-
Other taxes payable	565	498
Other payables	1,150	1,206
Total current trade and other payables	5,984	7,390
Of which payables from NHS and DHSC group bodies:		
Current	515	1,114

Note 19.1 Provisions for liabilities and charges analysis

	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2019	65	626	691
Arising during the year	51	705	756
Utilised during the year	(57)	(8)	(65)
Reversed unused	(28)	(233)	(261)
At 31 March 2020	31	1,090	1,121
Expected timing of cash flows:			
- not later than one year;	31	1,090	1,121
Total	31	1,090	1,121

The obligations categorised as 'Legal Claims' relate to provisions made by the Trust in respect of clinical negligence claims recognised by NHS Resolution on the Trust's behalf. The provision balance relates to the excesses that are expected to become payable on these claims.

The obligations categorised as 'Other' relate to provisions made by the Trust for Medical Pay Arrears, Employees on Fixed Term Contracts, VAT Recovered under COS Heading 14, Clinical Pension Tax Reimbursements and potential costs associated with Employment Relations and Tribunals.

Note 19.2 Clinical negligence liabilities

At 31 March 2020, £341,000 was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Dudley and Walsall Mental Health Partnership NHS Trust (31 March 2019: £290,000).

Note 20 Contractual capital commitments

	31 March	31 March 2019
	2020	
	£000	£000
Property, plant and equipment	378	204
Intangible assets	13	-
Total	391	204

Note 21 Financial instruments

Note 21.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners, and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and therefore sterling based. The Trust has no overseas operations. The Trust therefore has no exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust has no borrowings and therefore has no exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 21.2 Carrying values of financial assets

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2020		
Trade and other receivables excluding non financial assets	5,139	5,139
Cash and cash equivalents at bank and in hand	14,574	14,574
Total at 31 March 2020	19,713	19,713

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2019		
Trade and other receivables excluding non financial assets	4,101	4,101
Cash and cash equivalents at bank and in hand	18,818	18,818
Total at 31 March 2019	22,919	22,919

Note 21.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2020		
Trade and other payables excluding non financial liabilities	4,669	4,669
Provisions under contract	1,121	1,121
Total at 31 March 2020	5,790	5,790

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019		
Trade and other payables excluding non financial liabilities	6,248	6,248
Provisions under contract	691	691
Total at 31 March 2019	6,939	6,939

Note 21.4 Fair values of financial assets and liabilities

Book values (carrying values) of financial assets and liabilities are a reasonable approximation of fair value.

Note 21.5 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	5,790	6,939
Total	5,790	6,939

Note 22 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Fruitless payments	10	4	15	6
Bad debts and claims abandoned	-	-	-	-
Total losses	10	4	15	6
Special payments				
Ex-gratia payments	6	1	27	1
Total special payments	6	1	27	1
Total losses and special payments	16	5	42	7

Note 23 Related parties

In relation to related parties, the Trust has considered materiality from the perspective of the Trust and that of the Trust's counter parties and set materiality at an appropriate level.

During the year none of the Department of Health and Social Care Ministers, the Trust's Board of Directors or members of the key management staff, or parties related to any of them, have undertaken any material transactions with Dudley and Walsall Mental Health Partnership NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year Dudley and Walsall Mental Health Partnership NHS Trust has had a number of material transactions with entities for which the Department of Health and Social Care is regarded as the parent Department. These included:

	Income 2019/20	Expenditure 2019/20	Receivables 31 March 2020	Payables 31 March 2020
	£000	£000	£000	£000
Birmingham and Solihull Mental Health NHS FT	28	183	11	3
Black Country Partnership NHS FT	660	928	531	118
The Dudley Group of Hospitals NHS FT	0	2,491	0	87
West Midlands Ambulance Service University NHS FT	102	0	0	0
Sandwell and West Birmingham Hospitals NHS Trust	0	318	0	6
The Royal Wolverhampton NHS Trust	99	201	8	57
Walsall Healthcare NHS Trust	169	608	42	105
NHS Birmingham and Solihull CCG	901	0	315	0
NHS Cannock Chase CCG	174	0	7	0
NHS Dudley CCG	31,879	0	725	0
NHS Sandwell and West Birmingham CCG	2,433	11	48	3
NHS South East Staffs and Seisdon Peninsular CCG	195	0	17	0
NHS Walsall CCG	31,661	0	1,212	0
NHS Wolverhampton CCG	2,718	0	435	0
NHS England	3,358	98	625	0
Health Education England	2,705	0	46	0
NHS Resolution	0	241	0	0
NHS Property Services	0	310	0	6
Community Health Partnership	0	99	0	128

In addition, the Trust has had a number of material transactions with other Government Departments and Other Central and Local Government Bodies. These included:

	Income 2019/20	Expenditure 2019/20	Receivables 31 March 2020	Payables 31 March 2020
	£000	£000	£000	£000
HM Revenue and Customs	0	4,643	0	1,313
NHS Pension Scheme	0	8,269	0	0
Dudley Metropolitan Borough Council	1,108	142	423	0
Walsall Metropolitan Borough Council	312	4	49	1

Note 24 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	15,834	33,956	17,100	30,588
Total non-NHS trade invoices paid within target	14,370	32,069	14,893	28,974
	<hr/>	<hr/>	<hr/>	<hr/>
Percentage of non-NHS trade invoices paid within target	90.75%	94.44%	87.09%	94.72%

NHS Payables

Total NHS trade invoices paid in the year	838	8,101	530	5,354
Total NHS trade invoices paid within target	743	7,079	482	5,010
	<hr/>	<hr/>	<hr/>	<hr/>
Percentage of NHS trade invoices paid within target	88.66	87.38	90.94	93.57
	<hr/>	<hr/>	<hr/>	<hr/>
	%	%	%	%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 25 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2019/20 £000	2018/19 £000
Cash flow financing	4,391	(698)
Other capital receipts	-	0
External financing requirement	4,391	(698)
External financing limit (EFL)	4,391	1,421
Under / (over) spend against EFL	-	2,119

Note 26 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	6,127	3,351
Charge against Capital Resource Limit	6,127	3,351
	<hr/>	<hr/>
Capital Resource Limit	6,489	3,352
Under / (over) spend against CRL	362	1

Note 27 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	1,629
Remove impairments scoring to Departmental Expenditure Limit	-
Breakeven duty financial performance surplus / (deficit)	1,629

Note 28 Breakeven duty rolling assessment

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty should be 2009/10

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	376	883	1,163	3,575	1,936	888	1,960	2,199	3,384	3,050	1,629
Breakeven duty cumulative position	578	1,461	2,624	6,199	8,135	9,023	10,983	13,182	16,566	19,616	21,245
Operating income	66,578	67,918	67,298	71,302	65,388	64,750	64,546	66,293	69,482	74,340	81,986
Cumulative breakeven position as a percentage of operating income	0.9%	2.2%	3.9%	8.7%	12.4%	13.9%	17.0%	19.9%	23.8%	26.4%	25.9%

The breakeven cumulative net surplus of the Trust has exceeded 0.5% of operating income of the reporting year in every year of the breakeven period. The main reason for this is consistent delivery of in-year control totals as currently set by NHS Improvement.

PART D GLOSSARY

This glossary describes the acronyms used in this report.

Acronyms	Phrase	Description
ASC	Adult Social Care	A section of the local councils.
BAF	Board Assurance Framework	Reporting infrastructure which enables the Board to monitor progress against the Trust's strategic objectives.
BCM	Business Continuity Model	The BCM policy describes the strategic framework of how the Trust manages its business continuity planning.
BME	Black and Minority Ethnic	
BCPFT	Black Country Partnership NHS Foundation Trust	Our partner provider in the Black Country, delivering mental health and learning disability services.
BPPC	Better Payment Practice Code	This is a target that NHS organisations will pay 95% of bills within contract terms or in 30 days where there are no terms agreed.
BREEAM		An assessment using scientifically based sustainability metrics and indices that covers a range of environmental issues. Its categories evaluate energy and water use, health and wellbeing, pollution, transport, materials, waste, ecology and management processes.
CAEC	Clinical Audit Effectiveness Committee	To review lessons learned from enquiries and capture actions from internal and external reviews.
CAMHS	Child and Adolescent Mental Health Services	Mental Health services for under-18s. NB – inpatient beds for under-18s in Dudley and Walsall are provided by Birmingham Children's Hospital.
CARM	Contract Activity review Meeting	The contract performance review meeting template is a list of items that should be covered off during a contract and performance review meeting. These meetings can take place annually, bi-monthly or quarterly depending on the complexity of the contract and the desired level of performance monitoring.
CCA	Civil Contingencies Act 2004	The Civil Contingencies Act 2004 is an Act of the Parliament of the United Kingdom that makes provision about civil contingencies. It also replaces former Civil Defense and Emergency Powers legislation of the 20th century.
CCG	Clinical Commissioning Group	They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CCQI	Royal College of Psychiatrists Centre for Quality Improvement	The CCQI provide national initiatives which aim to improve standards of care in mental health services. They engage directly with managers, clinicians, and service users and support them to take responsibility for improving local services. CCQI also recognises local achievement, offering accreditation.
CEO	Chief Executive Officer	The chief executive officer or just chief executive, is the most senior corporate, executive, or administrative officer in charge of managing an organization – especially an independent legal entity such as a company or nonprofit institution.
CIP	Cost improvement Programme	Annual targets for reducing costs.
CPA	Care Programme Approach	An overall clinical approach which covers the assessment of individuals' needs, the planning of their care, evaluation of progress and review of treatment. As a result, of CPA, a 'Care Plan' is developed and agreed with the service user; this is a comprehensive description of all aspects of the person's care and treatment.
CQC	Care Quality Commission	Quality regulator for health and social care providers. In 2010, introduced a system of 'registering' providers as a demonstration of quality.
CQUIN	Commissioning for Quality and Innovation	CQUIN is a national initiative which aims to embed quality improvements within the commissioning cycle for NHS healthcare. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.
CRL	Capital Resource Limit	The capital resource limit (CRL) is applicable to NHS trusts only and controls the amount of capital expenditure an NHS trust may incur in a year. NHS trusts require CRL to cover all capital expenditure and must not incur expenditure in excess of this limit
CRS	Community Recovery Service	There are two Community and Recovery Teams in each of the Dudley and Walsall localities. The team will provide services to people who have a range of severe and persistent mental health problems and require ongoing treatment and interventions. They may also have substantial or critical social care needs directly associated with their mental illness. The service aims to improve independence and access

Acronyms	Phrase	Description
		to community care, and increase stability in the lives of service users and their carers.
DIHC	Dudley Integrated Health Care Trust	A new trust providing integrated health and care in Dudley aligned to primary care networks
DIPC	Director of Infection Prevention and Control	An individual with overall responsibility for infection control and accountable to the registered provider.
DSPT	The Data Security and Protection Toolkit	The Data Security and Protection Toolkit (DSPT) superseded the IG Toolkit, the DSPT is based upon the National Data Guardian Standards. Unlike the previous IG Toolkit, the DSPT does not provide a score or rating of the assessment so the Trust either met or did not meet the DSPT standard.
EAP	Employee Assistance Programme	This all employees with a 24 hours advice and support line covering a range of wellbeing advice options and signposting to relevant NHS, 3 rd sector and voluntary services.
EBE	Expert by Experience	'Expert By Experience' use their experiences of mental health services - as a service user or a carer of someone with mental health problems - to inform and influence the delivery, planning and quality of services.
EFL	External Finance Limit	
EPR	Electronic Patient Record	EPR is a systematized collection of patient and population electronically-stored health information in a digital format
EPRR	Emergency Preparedness, Resilience and Response	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This could be anything from extreme weather conditions to infectious disease outbreak or a major transport accident or terrorist attack. This work is referred to in the health service as "emergency preparedness, resilience and response"
EqIA's	Equality Impact Analysis (Assessments)	
ESR	Electronic Staff Record	The Trust reports training compliance on all levels of training. All records of attendance are entered onto and monitored via the Trust Electronic Staff Record (ESR) system
FFT	Friends and Family Test	The Staff Friends and Family Test is a simple feedback tool that allows staff to give their feedback on NHS services
F&P	Finance and Performance Committee	This is a sub-committee of the Trust Board that meets monthly
FYFV	Five Year Forward View	This document sets out a new shared vision for the future of the NHS based around the new models of care.
FT	Foundation Trust	Type of NHS provider organisation which has more autonomy and different governance arrangements. FTs are authorised and regulated by NHSI.
FTE	Full Time Equivalent	An FTE is the hours worked by one employee on a full-time basis. The concept is used to convert the hours worked by several part-time employees into the hours worked by full-time employees.
GDPR	General Data Protection Regulations	The General Data Protection Regulation 2016/679 is a regulation in EU law on data protection and privacy for all individuals within the European Union and the European Economic Area. It also addresses the export of personal data outside the EU and EEA areas
GP	General Practitioner	A doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.
HR	Human Resources	Human resources are the people who make up the workforce of an organization, business sector, or economy
HSE	Health and Safety Executive	
HSJ	Health Service Journal	
H&S	Health and Safety	
HPMA	Healthcare People Management Association	The Healthcare People Management Association is the professional voice of HR in healthcare.
IAPT	Improving Access to Psychological Therapies	An NHS programme rolling out services across England offering interventions for treating people with depression and anxiety disorders.
IFRS	International Financial Reporting Standards	International Financial Reporting Standards, usually called IFRS, are standards issued by the IFRS Foundation and the International Accounting Standards Board to provide a common global language

Acronyms	Phrase	Description
		for business affairs so that company accounts are understandable and comparable across international boundaries
IG	Information Governance	Information governance, or IG, is the management of information at an organization. Information governance balances the use and security of information. Information governance helps with legal compliance, operational transparency, and reducing expenditures associated with legal discovery.
IM&T	Information Management and Technology	
IPS	Individual Placement Support	Individual Placement Support helps people with a long term Physical or Mental Health condition get back into work.
KPI	Key Performance Indicators	These are measures of performance and are used by the Trust to evaluate levels of success in achieving its goals
LCFs	Local Counter Fraud Specialist	
LD	Learning Disabilities	LD Services aren't provided by DWMHPT
MERIT	Mental Health Alliance for Excellence, Resilience, Innovation and Training	Four mental health trusts in the West Midlands have come together in a new healthcare alliance to transform the way acute mental health services are provided.
MExT	Management Executive Team	A regular meeting. The Management Executive of the Trust meet regularly to discuss relevant Trust business and progresses.
MHAS	Mental Health Assessment Service	
MH/LD	Mental Health / Learning Disabilities	
NCMH	National Centre for Mental Health	Looks at genetic causes of mental health problems
NHS	National Health Service	The NHS provides free healthcare, regardless of wealth, for resident in the UK. It covers everything from antenatal screening and routine treatments for long-term conditions, to transplants, emergency treatment, and end-of-life care.
NHSE/I	National Health Service England / Improvement	NHS England and NHS Improvement have come together as a single organisation. Their aim is to better support the NHS and help improve care for patients.
NICE	National Institute for Health and Clinical Excellence	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health
OD	Organisational Development	The development, implementation and review of various strategies and plans to improve an organisation
PC-MIS	Primary Care Management Information System	PC-MIS are implemented in less developed countries with the expectation that they will contribute to improving Primary Health Care delivery. Information generated through these systems is conceived as an imperative for better decision making processes and strengthening accountability arrangements that underpin the delivery of PHC.
PDC	Public Dividend Capital	This is a payment made each year by the Trust to the Department of Health to reflect the investment they have provided. It is calculated at 3.5% of the Trust's asset base and is generally regarded as being equivalent to the long term cost of capital in the public sector.
PHSO	Public Health Service Ombudsman	The Parliamentary and Health Service Ombudsman (PHSO) comprises the offices of the Parliamentary Commissioner for Administration (PCA) and the Health Service Commissioner for England (HSC). The Ombudsman is independent of both the Government and the civil service and reports annually to both Houses of Parliament
PLACE	Patient Led Assessment of the Care Environment	A national programme of assessment managed by the National Patient Safety Agency. PLACE is a benchmarking tool which helps demonstrate how well healthcare providers are performing in non-clinical aspects of patient care, focusing on care environment, food, privacy and dignity.
POMH	Prescribing Observatory for Mental Health	Services that are members of POMH-UK take part in audit-based QIP's that focus on specific topics within mental health prescribing practice and reduce risks associated with medicines management.
PPC	Prompt Payment Code	The Prompt Payment Code (PPC) sets standards for payment practices and best practice. The code is administered by the Chartered Institute of Credit Management. Dudley and Walsall Mental Health Partnership NHS Trust signed up to the code in October 2009.
PPPH	Patient Preferences for Psychological Help	The aim of this study is to learn more about patient difficulties so that we can improve the psychological help offered in the future. Developing personalised psychological interventions for patients with

Acronyms	Phrase	Description
		non-affective psychosis.
PREM's	Patient Reported Experience Measures	PREMS are used to understand service users' views on their experience while receiving care. A standard set of core questions has been developed that are linked to the CQC's CREWS domains and will be asked in every service area to explore in more depth the experience across our services, to highlight areas of good practice and any potential areas for improvement.
PSED	Public Sector Equality Duty	
QIA	Quality Impact Assessments	The Trust has an effective Quality Impact Assessment process in place to ensure that quality of care is not compromised through its Cost Improvement Plans. Quality and Equality Impact assessments have been completed for all service transformation developments and cost improvement programmes. QIAs are designed to ensure that service transformation plans place quality and safety improvement as the highest priority.
QH	Quality Health	An organisation that carries out surveys including the NHS patients and staff surveys.
Q&S	Quality and Safety Committee	The Trust's Quality and Safety Committee has overarching responsibility for quality and for the monitoring and assurance of quality performance.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	RIDDOR puts duties on employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).
SED	Service Experience Desk	The Trusts team that handles complaints concerns and compliments
SIRO	Senior Information Risk Owner	The named lead within the Trust.
STP	Sustainability and Transformation Plans	The aim of this plan is to address on a larger scale the gaps in health and well-being, quality and care and finance and efficiency.
TCP	Transforming Care Partnership	Transforming Care Partnerships. TCPs are made up of clinical commissioning groups, NHS England's specialised commissioners and local authorities. They work with people with a learning disability, autism or both and their families and carers to agree and deliver local plans for the programme.
TCT	Transforming Care Together	A planned partnership agreement between the Trust, Birmingham Community Healthcare NHS Foundation Trust and Black Country Partnership NHS Foundation Trust that has subsequently dissolved.
UKCP18	UK Climate Projections 2018	The UK Climate Projections (UKCP) provides the most up-to-date assessment of how the climate of the UK may change over the 21st century.
WDES	Workforce Disability Equality Standard	The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (Metrics) which enables NHS organisations to compare the workplace experiences of Disabled and non-disabled staff. NHS organisations use the Metrics data to develop an action plan and enable them to demonstrate progress against the indicators of disability equality.
WMCA	West Midlands Combined Authority	18 local authorities and three Local Enterprise Partnerships (LEPs) working together to move powers from Whitehall to the West Midlands and its locally elected politicians, who know this region best.
WRES	Workforce Race Equality Standard	The WRES is a tool designed for both providers of NHS services (this includes NHS providers, independent sector, and voluntary sector providers of NHS services) and NHS commissioners. It can also be applied to national healthcare bodies; indeed, many national healthcare bodies are also implementing and using the WRES.
WTE	Whole Time Equivalent	

Dudley and Walsall Mental Health Partnership NHS Trust



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